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# MICHIGAN MEDICINE

## the journal of the michigan state medical society

January 1965 • Vol. 64 • No. 1

*Please Return Questionnaire, Page 52A*

*Why Don't We Control Syphilis? Page 17*

*County Societies Set Fast Pace, Page 49*

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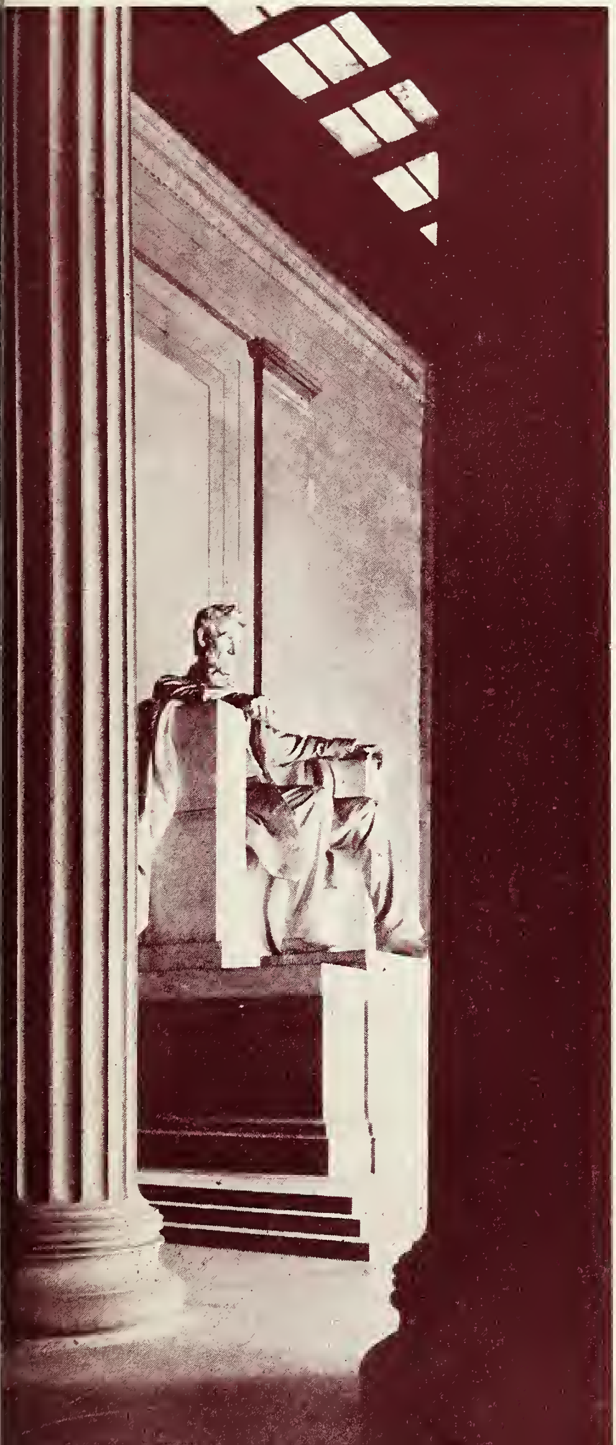

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*Roseman, E.: *Neurology* **11**:912, 1961. 33664

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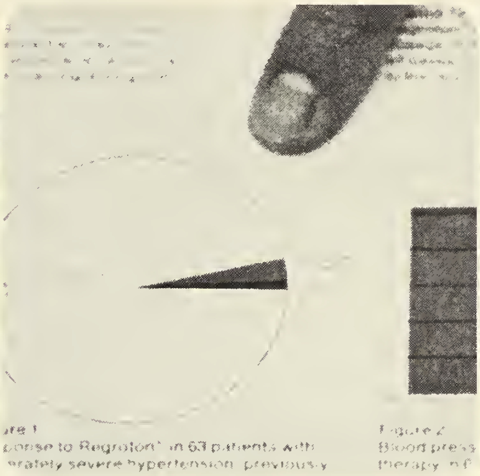
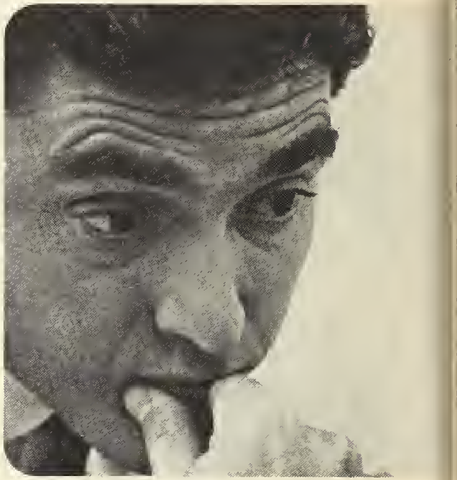

Says this 2-year study by Finnerty.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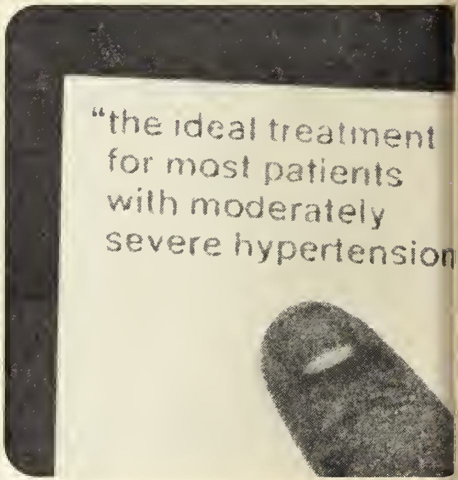
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For full details, see the complete prescribing information.

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*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone plus reserpine in moderately severe and severe hypertension: A two year study. Presented at the 7th Inter-American Congress of Cardiology, Montreal, June 14–19, 1964.

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"the ideal treatment for most patients with moderately severe hypertension"*

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MICHIGAN MEDICINE

the journal of the michigan state medical society

January, 1965 • Vol. 64 • No. 1

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Published monthly except two extra issues to be published in October and December, by the Michigan State Medical Society as its official journal at 2642 University Avenue, Saint Paul, Minnesota 55114.

Second class postage paid at Saint Paul, Minnesota.

Yearly subscription rate, $9.00; single copies, 80 cents. Additional postage: Canada, $1.00 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year.

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# *President's Message*

## Public Relations Expense

By OLIVER B. McGILLICUDDY
MSMS President

Your Michigan State Medical Society budgets a good deal of money for public relations. Some have asked "Is all of this money needed?"

Public Relations begin in the doctor's office but they don't end there. Many facets of this activity require the organized efforts of a large society. Your investment is handled by experts who carefully evaluate the public relation impact of their expenditures. The budget is conscientiously surveyed by economy-minded members of The Council.

There is need for constant state-wide public relations activity. Although our work during the past year increased fees from governmental agencies from depression levels to a more equitable rate, this remuneration still does not approach the fair and average fees called for by our House of Delegates. Further, even though the total additional compensation to the medical profession in Michigan from increased government payments to doctors in 1964 was comparable to the total annual budget of MSMS, yet the amounts paid are not, comparably, as high as those paid by the government for other services.

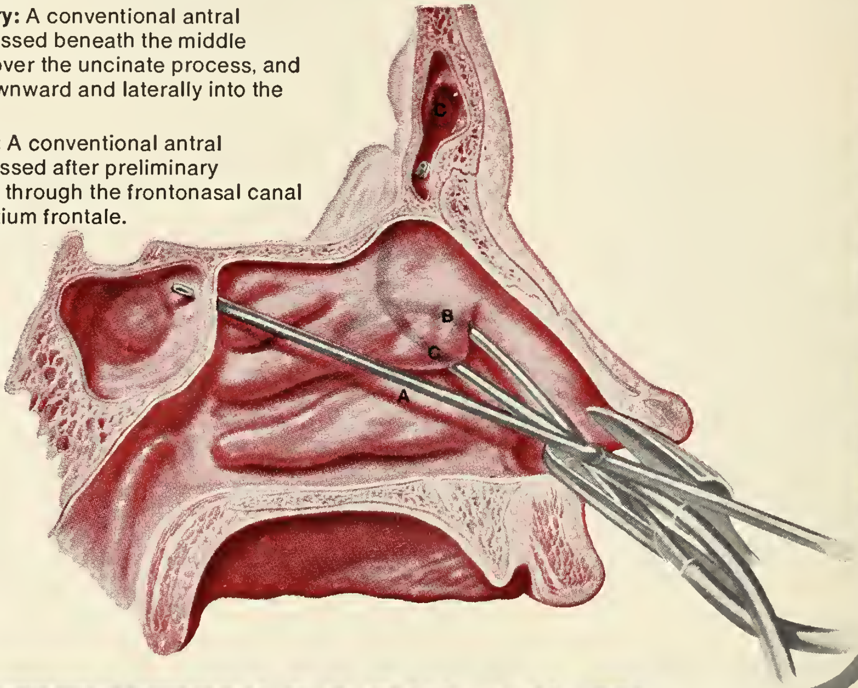
Your state society has continuing liaison with a host of organizations and governmental departments.

It sponsors radio and TV shows and originates thousands of releases of medical interest to the press. The society maintains a speaker's bureau, and its members spend hours and days in a year speaking to lay groups. There is, I am sure, no organization of its size that has as many devoted contributors of their time.

Public Relations includes generous support of the Health Council which MSMS developed and which has as one of its projects the placing of doctors in rural communities. Our example has stimulated the donations of many other organizations to this very worthwhile effort.

The MSMS Public Relations Department has been most active in the education of the public on the advantages of good patient-doctor relationship and the superior qualities of the private practice of medicine. The continuing attacks of unfriendly bureaucrats and the misguided, uninformed arguments of magazine authors directed at the medical profession require an ever-increased effort of organized medicine.

The image of Medicine is at stake. The cost is not too high.



**A rhinologic approach to the sinuses**
Sagittal anatomical section of nasal cavity showing approach for probing or irrigation by cannulas.

**A—Sphenoid:** A sphenoid cannula (under 13.5 cm.) passed around the middle and superior turbinates to the anterior wall of the sinus through its ostium.

**B—Maxillary:** A conventional antral cannula passed beneath the middle turbinate, over the uncinate process, and rotated downward and laterally into the ostium.

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*Reed, G. F.: Sinusitis, New England J. Med. 267:402, Aug. 23, 1962.

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## INFORMATION FOR READERS / CONTRIBUTORS:

### GENERAL INFORMATION:

MICHIGAN MEDICINE is the official organ of the Michigan State Medical Society, published monthly under the direction of the Publication Committee. A copy is sent to each member of the Society.

*Notice of change of address should be sent promptly to the Michigan State Medical Society, P.O. Box 152, East Lansing, Michigan.*

Members are invited to submit to the Journal any suggestions for the welfare of the Society, as well as comments or criticisms of any material in the Journal. All such communications should be directed to the Publication Committee of the Journal. The Publication Committee reserves the right to publish, reject, edit, or abbreviate all communications submitted to it.

### ADVICE TO AUTHORS:

1. Address scientific manuscripts to Editor, MICHIGAN MEDICINE, C. J. Tupper, M.D., 2490 Adare, Ann Arbor, Michigan.
2. Submit original, double-spaced, typewritten copy and one carbon copy on letter size (8½ x 11 inch) paper.
3. On page one, include title, authors, degrees, academic titles, and any institutional or other credits.
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5. Illustrations should be submitted in the form of glossy prints or original sketches from which cuts, or plates, will be made by the Journal. The Journal will pay the first $25 of the engraving bill, and the author shall pay the balance. An estimate of the cost will be submitted to authors before cuts are ordered.
6. References will ordinarily be limited to seven in number. Exceptions may occasionally be made.
7. Contributors will be notified as soon as practicable if a manuscript is accepted for publication. Unused manuscripts will be returned. Every care will be taken with the submitted material but the Journal will not hold itself responsible for loss or damage to manuscripts.
8. Articles should ordinarily be less than four printed pages in length (3000 words).
9. References should conform to *Cumulative Index Medicus*, including, in order: Author, title, journal, volume number, page, and year. Book references should include editors, edition, publisher, and place of publication, as well.
10. Specify address to which galley proof should be sent. Proofs will be mailed to authors for correction before publication and should be returned to the editor in 48 hours. If proofs approved by the author are not received by the editor prior to deadline, publication of the article will be cancelled for that issue.
11. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.
12. It is understood that material is submitted for exclusive publication in MICHIGAN MEDICINE.

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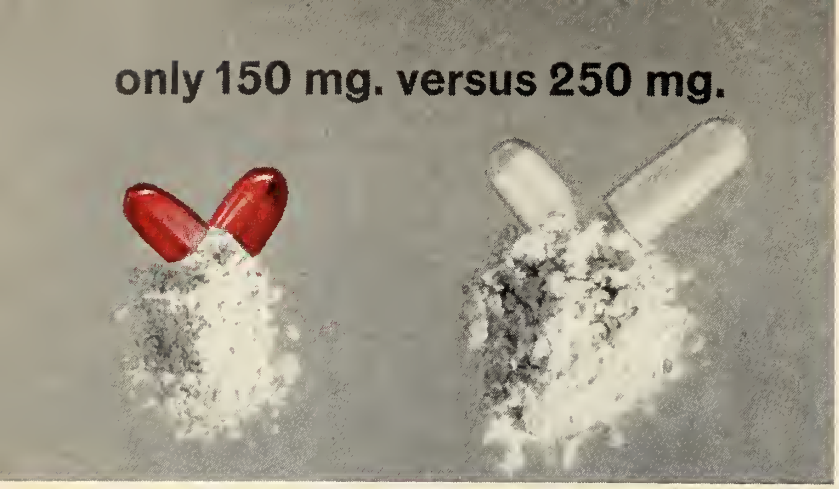

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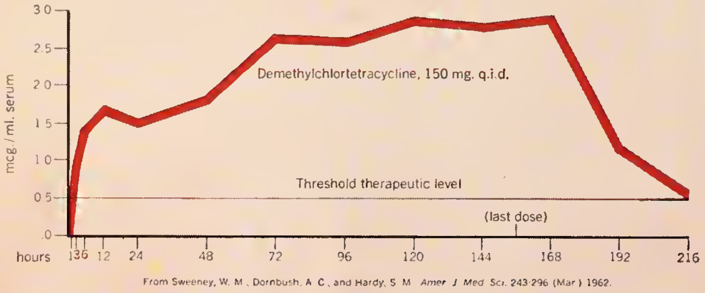

From Sweeney, W. M., Dornbush, A. C., and Hardy, S. M. Amer. J. Med. Sci. 243:296 (Mar.) 1962.

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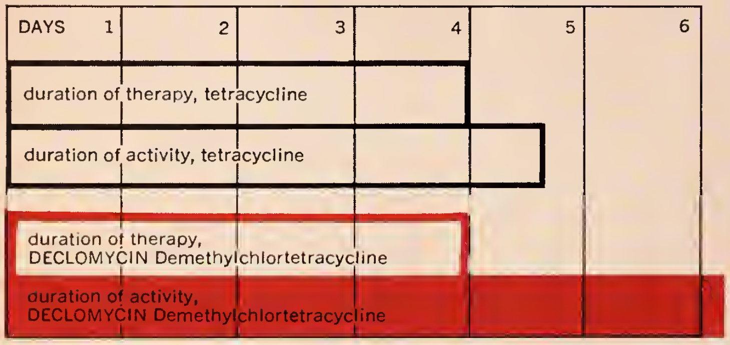

## gives you an "extra dimension" of antibiotic control

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**Side Effects** typical of tetracyclines which may occur: glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms. Also: photodynamic reaction (making avoidance of direct sunlight advisable) and, very rarely, anaphylactoid reaction. Reduce dosage in impaired renal function. The possibility of tooth discoloration during development should be considered in administering any tetracycline in the last trimester of pregnancy, in the neonatal period, and in early childhood. **Capsules,** 150 mg. and 75 mg. of demethylchlortetracycline HCl. *Average Adult Daily Dosage:* 150 mg. q.i.d. or 300 mg. b.i.d.

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# good reason for good results in a wide variety of infections

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Ahead of its time for 14 years, Terramycin remains a broadly effective and dependable antibiotic with a fine record — confirmed by more than 6,000 published papers. Moreover, the incidence of serious adverse effects has been remarkably low.

1. Kunin, C. M. et al.: J. Clin. Invest. 38:1950, Nov., 1959.

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**Contraindicated:** In patients hypersensitive to oxytetracycline.
**Warning:** Reduce usual dosage and consider antibiotic serum level determinations in patients with impaired renal function. Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth.
**Precautions:** Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy.
All precautions applicable to intramuscular injection should be carefully observed. Intramuscular solutions should be injected well within the body of a relatively large muscle, such as the upper outer quadrant of the buttock or the lateral thigh; do not inject into the lower or middle thirds of the upper arm. Care should always be taken to avoid injecting into a blood vessel or major nerve. Subcutaneous or fat-layer injection should be avoided.
**Adverse Reactions:** Nausea, diarrhea, glossitis, stomatitis, proctitis, vaginitis and dermatitis, as well as reactions of an allergic nature, may occur but are rare.
**Supply:*** Terramycin Capsules: oxytetracycline HCl, 250 mg. and 125 mg. Terramycin Syrup: calcium oxytetracycline, 125 mg. per 5 cc. Terramycin Pediatric Drops: calcium oxytetracycline, 100 mg. per cc. Terramycin (oxytetracycline) Intramuscular Solution: available as ampules containing 100 or 250 mg. oxytetracycline/2 cc., Isoject® syringes containing 100 or 250 mg. oxytetracycline/2 cc. and 10 cc. multiple dose vials containing 50 mg. oxytetracycline/cc.

*All potencies listed are in terms of the standard, oxytetracycline.

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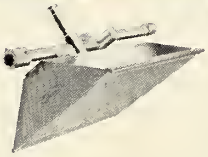

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# NEWS BRIEFS

Flint electors chose 9 of 45 candidates to comprise the Flint Charter Revision Commission at the November election—and selected two doctors, **Lucile Limback, M.D.**, and **John C. Rawling, M.D.**

Guest speakers at the annual session of the International Medical Assembly of Southwest Texas in San Antonio, January 28-30, will include **Joseph Beninson, M.D.**, Detroit; **John M. Weller, M.D.**, and **Harold F. Falls, M.D.**, both of Ann Arbor.

Among the speakers selected for the Loma Linda University School of Medicine Alumni Postgraduate Conference in Los Angeles, March 5-11, is **Alan P. Thal, M.D.**, Detroit.

One of the vice presidents of the Michigan Junior Chamber of Commerce this year is **Thomas R. Berglund, M.D.**, of Portage Road, Kalamazoo.

**David C. Boyce, M.D.**, Grand Rapids, was one of five flying physicians who discussed aero-space medicine at the Southern Medical Association meeting in Memphis in November.

**Albert E. Heustis, M.D.**, director of the Michigan Department of Health, has been chosen secretary-treasurer of the Association of State and Territorial Health Officers.

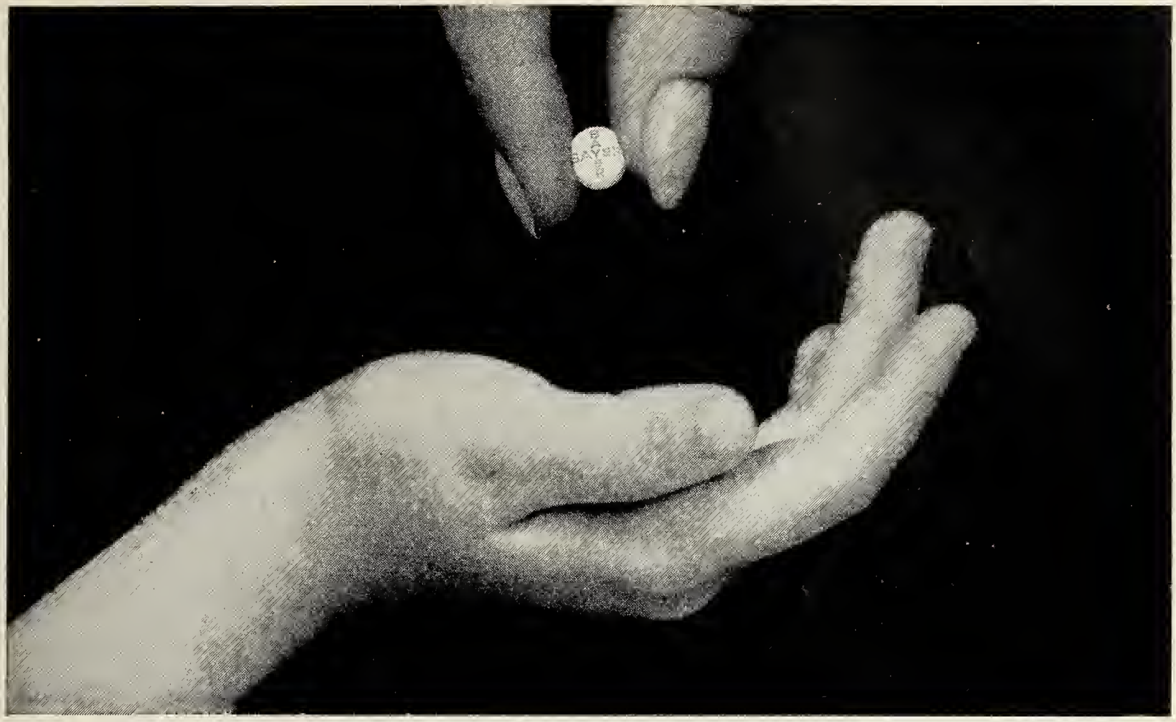
The Midwest Forum on Allergy held in Detroit recently included a panel presentation entitled "Pathophysiology of Atopic Eczema". **Sidney Friedlaender, M.D.**, Detroit, was moderator, with **Hermann Pinkus, M.D.**, Monroe; **Clarence Livingood, M.D.**, Detroit; and **Arthur C. Curtis, M.D.**, Ann Arbor, as panelists.

**Joseph S. Jacob, M.D.**, Detroit, discussed "the influence of the integrative process on self-image" at the December meeting of the Detroit Psychoanalytic Society.

A Distinguished Faculty Achievement Award of $1,000 has been given to **Reed M. Nesbit, M.D.**, professor of surgery, University of Michigan School of Medicine.

**Ezra V. Bridge, M.D.**, Port Huron, has been named chairman of the research and medical education committee of the Michigan Tuberculosis and Respiratory Disease Association.

*(Continued on Page 12)*



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your young patients get the aspirin
dosage you want them to have

The answer is Orange Flavored Bayer Aspirin for Children

The dosage is 1¼ grains per tablet. Mothers place such confidence in the Bayer name. And the new orange flavor is so fresh and smooth that children take it readily. (The grip-tight cap on the bottle helps keep them from taking it on their own.)

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*(Continued from Page 10)*

**Julius Rutzky, M.D.**, Pontiac, will use a $15,000 grant from the Children's Leukemia Foundation of Michigan to continue his research at Pontiac St. Joseph Mercy Hospital on the amniotic fluid surrounding the newborn child.

Feted at a community dinner at Birch Run recently was **Thomas E. Fleschner, M.D.**, who was honored for 31 years of medical service. Testimonial plaques were presented by the VFW, the High School Athletic Department, and Lions Club.

**Herbert A. Raskin, M.D.**, Birmingham, served in November on a team of consultants to the Japanese government on the problem of drug addiction and alcoholism. The joint Japanese-American Conference was sponsored by the Office of International Scientific Activities of the National Science Foundation.

To continue research in neurological sciences, the Kresge Foundation has granted $31,000 to the Wayne State University. The work is being directed by **E. S. Gurdjian, M.D.**, chairman of neurosurgery, who also received $16,864 from the National Institutes of Health for neurological research.

Formerly of Three Rivers, **Dale C. Weir, M.D.**, received a pin from the Indiana State Medical Society for 50 years of service. He now lives in Louisville, Kentucky.

**C. B. Mandeville, M.D.**, a Past President of the Muskegon County Medical Society, has moved to Tacoma, Washington, to practice there with his son, Jack, an opthalmologist.

MSMS Councilor **James Dehlin, M.D.**, discussed medical safety in the home at the meeting of the Soo Hill PTA at Escanaba.

**Donna Hislop**, Muskegon, and **Marjorie Orr**, Saginaw, were among 37 certified in 1964 under the program established by the American Association of Medical Assistants. They were recipients of "administrative certification."

**Marjorie Balmer**, of the Oakwood Hospital, Dearborn, recently was elected to the Board of Directors of the American Association of Medical Record Librarians.

**R. W. Wilkins, M.D.**, was recently elected to the Board of Directors of the First National Bank of Monroe.

A warm feature in the *Adrian Daily Telegram* about **Eleanor Parshall Skufis, M.D.**, Lenawee County Health Department director, as "a human dynamo." The interviewer quoted Doctor Skufis' concern that "public health work sometimes gets frustrating because medicine changes so rapidly and the law so slowly."

The speakers at the "Bronson Hospital Medical Careers Day" at Kalamazoo included **Robert M. Nicholson, M.D.**

**Hygroton®**
**brand of chlorthalidone**
**the long-acting diuretic**

**Indications**
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**Contraindications**
Hypersensitivity, and most cases of severe renal or hepatic disease.
**Precautions**
Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
**Side Effects**
Constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, leukopenia, muscle cramps, nausea, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
**Average Dosage**
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**Availability**
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For full details, see the complete prescribing information.

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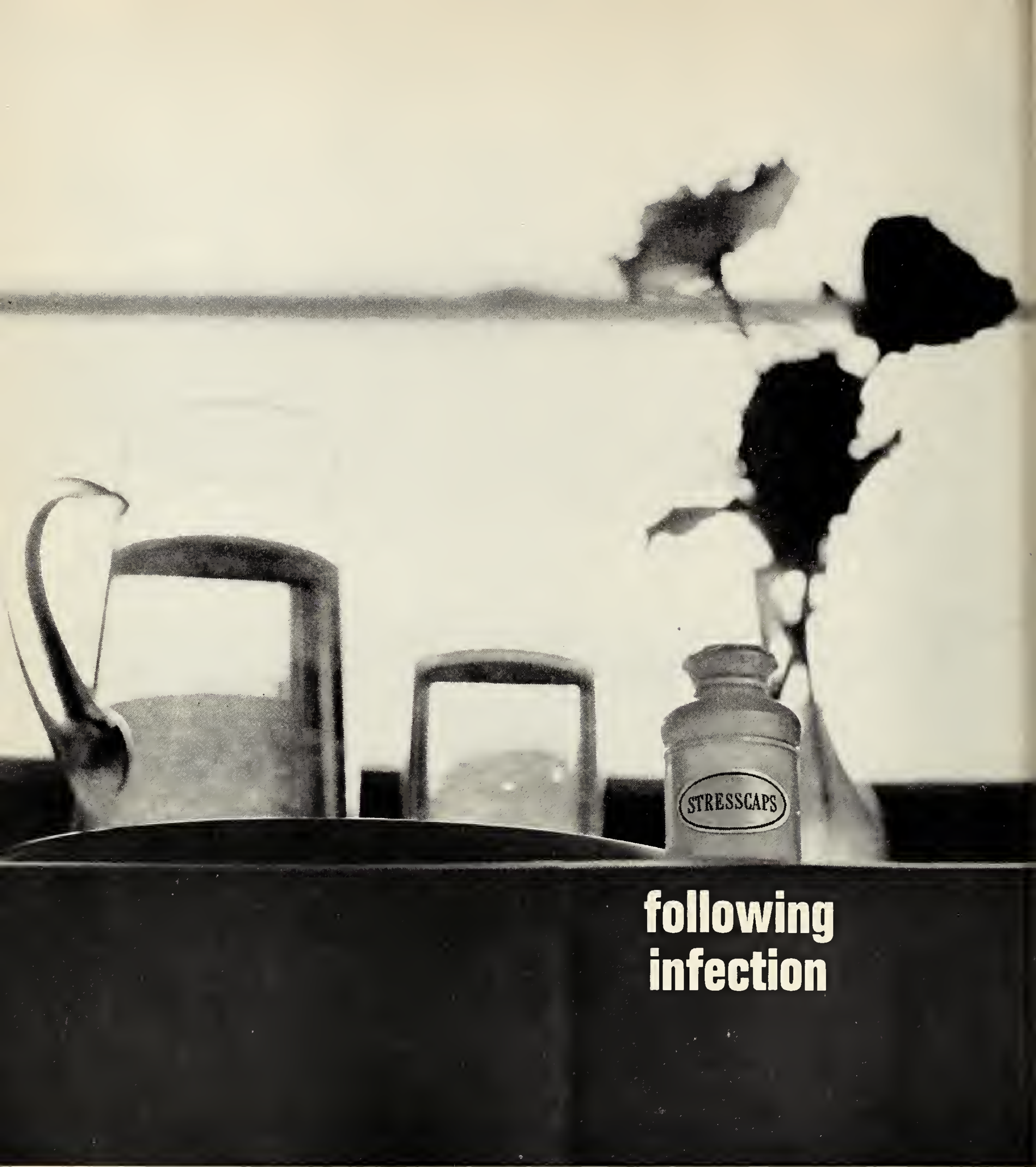

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1. Griffith, R. S., and Black, H. R.: Current Ther. Res., *6*:253, 1964.

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The reported incidence of infectious syphilis has increased each year since 1958. Public apathy and medical complacency are considered significant factors in this rise. Children between the ages of 10 and 19 are major contributors to this increase. Teaching about syphilis specifically and venereal disease in general has become a "stepchild" in the medical schools curriculum. The economics as well as the humanitarian costs of uncontrolled syphilis are enormous. The need for contact interviewing and contact investigation on every infectious syphilis case is demonstrated. Representative case histories related to this need are cited.

# Why Don't We CONTROL SYPHILIS?

By
JOHN A. COWAN, M.D., M.S., M.P.H., and WM. J. McCURRY, B.S.
Lansing

History reveals that syphilis and venereal diseases in general have made their greatest inroads on the population during periods of major social unrest.

It is significant that it was during such a period that the first official action taken in the United States designed to combat the venereal disease problem was the passage of the Chamberlain-Kahn Act of 1918. The high prevalence of venereal disease among the draft group prompted this action which provided the first Federal grant-in-aid program for public health.

The programs were short-lived, however, and by 1926 had been all but forgotten.

The first National Conference on Venereal Disease was called in 1936 and the conclusions of this conference were issued in the following statement:

"First, every early case must be located, reported, its source ascertained, and all contacts followed up to find possible infection. Second, enough money, drugs, and doctors must be secured to make treatment possible in all cases, it is not in the public interest for treatment, which is our most practical means of control, to be retarded or precluded by cost. Third, both public health agencies and private physicians throughout the country must be aligned to form a united front and re-educated to use of scientific modern methods in their joint fight against syphilis. In addition, citizens must be informed as to the means and methods required for individual and public protection."

In 1938, the LaFollette-Bullwinkle Bill was passed by Congress reestablishing grants-in-aid to states for prevention, treatment, and control of venereal diseases.

There is no doubt that new infections were occurring at an accelerated rate in the years prior to and during World War II. During this period the fight against syphilis reached its greatest intensity. Rapid treatment centers were established, numerous public venereal disease clinics were in operation, interviewing of infected patients and follow-up of their contacts was routine, and an all-out educational program which utilized all the mass media was underway. As expected, syphilis

SCIENTIFIC PAPERS

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TABLE I. REPORTED SYPHILIS CASES IN MICHIGAN

| Year | Primary & Secondary Syphilis | Total Syphilis (All Stages) |
|---|---|---|
| 1941 | 1,527 | 11,370 |
| 1942 | 1,731 | 12,461 |
| 1943 | 2,223 | 15,933 |
| 1944 | 2,810 | 17,288 |
| 1945 | 3,357 | 16,046 |
| 1946 | 4,553 | 18,051 |
| 1947 | 3,144 | 15,276 |
| 1948 | 2,084 | 12,100 |
| 1949 | 1,176 | 8,740 |
| 1950 | 604 | 8,830 |
| 1951 | 430 | 6,532 |
| 1952 | 294 | 7,377 |
| 1953 | 158 | 5,619 |
| 1954 | 171 | 4,686 |
| 1955 | 122 | 4,865 |
| 1956 | 99 | 4,785 |
| 1957 | 107 | 4,573 |
| 1958 | 85 | 4,267 |
| 1959 | 103 | 3,421 |
| 1960 | 204 | 3,647 |
| 1961 | 313 | 3,309 |
| 1952 | 316 | 3,571 |
| 1963 | 453 | 4,894 |

morbidity figures increased rapidly, reaching a peak in 1946 (Table I).

As the pool of untreated cases began to dwindle and chains of infection were broken because of the interviewing of infectious cases and follow-up of contacts, it became more difficult to discover new cases of syphilis and the cost of mass casefinding programs became more difficult to justify. By 1950, the rapid treatment centers were closed and the personnel force had been reduced to practically nothing. It appeared that syphilis was no longer a problem worth considering. Complacency began to replace the excitement of battle in spite of the warnings of a few who wisely predicted that syphilis would return.

The imaginative thinking that resulted in the use of penicillin in the treatment of venereal disease cases, mass blood testing programs which uncovered thousands of previously undetected cases, and the development and refinement of interviewing techniques was lacking during the years following 1952.

## MEDICAL SCHOOLS CURRICULA DE-EMPHASIZE SYPHILIS

Clinical syphilis cases were not evident in sufficient numbers to provide teaching material in our medical schools and syphilis, the intriguing disease which had fascinated physicians for many years, was all but dropped from the curriculum. As a result, many young physicians in practice today have never knowingly observed a case of early syphilis. The situation is stated very well by Dr. Harry Pariser in his article, "Seek and Ye Shall Find."[1] Doctor Pariser writes, "I worry about syphilis rapidly becoming a stepchild diagnosis in medical thinking."

Co-Author
JOHN A. COWAN,
M.D.

Normally, we refer to primary and secondary syphilis as the infectious stages. This assumption, however, needs some qualification.

## SYPHILIS—PERIOD OF COMMUNICABILITY

The period of communicability of syphilis is variable. It is definitely communicable during the primary and secondary stages. During these stages, the mucocutaneous lesions will yield Treponema Pallidum which can be identified by darkfield microscopy. It is also communicable during mucocutaneous recurrence intermittently during two to four years.[2] The extent of communicability during early latent syphilis, *by sexual intercourse*, has not been definitely established. For epidemiologic purposes, the first year is considered most infectious.[3] It should be remembered that the blood in latent syphilis can be infectious, as is obvious from the fact that pregnant women with latent syphilis can infect the fetus in utero.[4] There are also authenticated cases of transfusion syphilis acquired from persons with latent syphilis. T. pallida are probably seeded into the blood stream from foci of infection on numerous occasions during the course of latent syphilis.

For practical purposes, we consider syphilis to be communicable, by sex contact, during the primary and secondary stages and during the first year of latent syphilis.

## RISING TREND IN REPORTED SYPHILIS MORBIDITY

During the years between 1952 and 1958, the decline in reported cases of syphilis continued (Table I). But in 1959, a slight increase in primary and secondary syphilis was recorded. The upward trend continued and in 1963 the number of reported cases of primary and secondary syphilis was more than five times the number reported in 1958 (Table I).

This reversal of the morbidity trend is of course disturbing to most of us. Even more disturbing, however, is the fact that a considerable number of the reported infections are occurring in youngsters under the age of 20 years (Fig. 1). In fact, *the percentage increase in infections is greater among persons between the ages of 10 and 19 than the combined increase in all age groups,* and while this article has been limited to syphilis, it should be mentioned that the number of gonorrhea cases reported among Michigan's teenagers is even more alarming.

In considering the present trend in syphilis morbidity, or figures for any period, it is well to remember these factors:

1. Increasing primary and secondary syphilis morbidity figures in a given area may mean any one or a combination of the following:

(A) Syphilis incidence is increasing.

(B) The finding and identifying of cases in the earliest stages has been intensified.

(C) Private physicians are reporting a greater proportion of the cases which they diagnose.

2. Decreasing primary and secondary syphilis morbidity in a given area may mean any one or a combination of the following:

(A) Syphilis incidence is decreasing.

(B) Casefinding has become less effective.

(C) Fewer diagnosed cases are being reported.

It must not be overlooked, however, that in any given area, increasing incidence may co-exist with decreasing effectiveness of casefinding and/or reporting, and vice versa. So, in two areas, opposite combinations of factors may result in identical trends or even static figures.

One factor which may lend support to the belief that there is today a true increase in syphilis incidence is the fact that the upward trend in the reporting of primary and secondary syphilis is occurring throughout the nation. There is also evidence of a world-wide increase in syphilis indicated by the recent upward trend of incidence in 76 nations of the world.

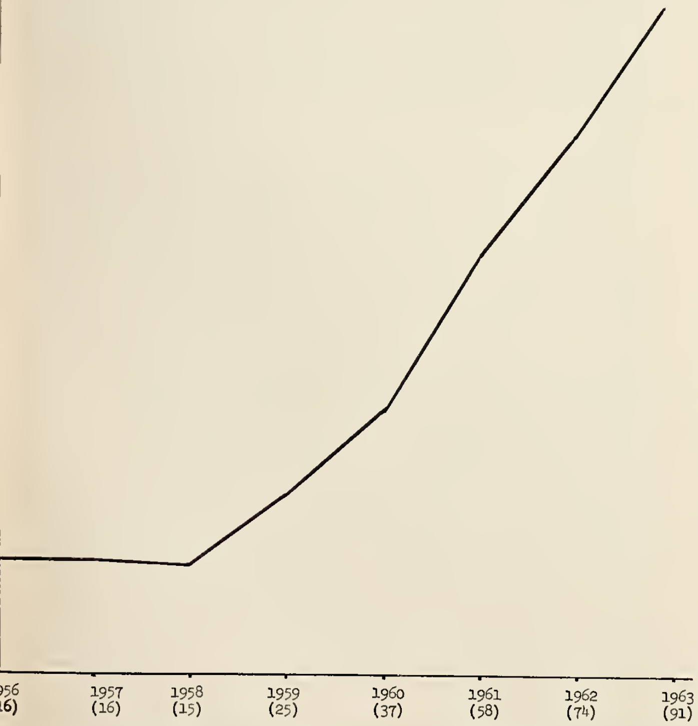

Fig. 1. Reported cases of primary and secondary syphilis among persons 10 to 19 years of age. Michigan, 1956-1963.

## THE COST OF UNCONTROLLED SYPHILIS

How important is it that we control syphilis in Michigan? There is, of course, no way of measuring the human suffering, anxieties, and embarrassment caused by this disease. We do know, however, that it cost the taxpayers of Michigan $1,765,870.00 last year to maintain in state-supported mental institutions 820 patients with chronic brain syndrome associated with central nervous system syphilis.[5] This obviously is only a part of the total cost of untreated or inadequately treated syphilis because it does not account for the care and treatment of the syphilitic blind nor those disabled because of cardiovascular and other types of complicated syphilis. Neither does it take into account the added welfare costs of aiding in the support of the families of many who have become disabled because of syphilis.

In 1963, the ratio of newly reported syphilis cases in the early stages, including early latent, was one for every seven cases in later stages. We cannot deny that this represents failure to control the disease. We must also assume that as long as cases are going undetected and untreated during the period of communicability, not only will the disease continue to spread, but a number of the victims will develop one or more of the serious complications of untreated syphilis.

There can be little doubt that syphilis still presents a threat to the public health of our state and to the nation as a whole. Is it not, then, in our common interest to combine our knowledge, our skills, and our resources in an all out effort to eliminate this public health hazard? History has shown us the results of complacency, disinterest, and ignorance in this matter. We know, from experience also, the ingredients of a program which can eventually accomplish the task. The necessary recommendations were outlined for us in 1936 and we have every reason to believe that the success in the ensuing years was brought about because these recommendations were followed.

## PHYSICIAN RESPONSIBILITY

First, we must ask ourselves, is our "index of suspicion" high enough? Are we really looking for syphilis among our patients? Do we use the available facilities for darkfield examination of all suspicious lesions? Are we conscious of our obligations to report promptly every diagnosed case of syphilis?

Although public venereal disease clinics are fewer in number today than in 1951, we find that these clinics are reporting more primary and secondary

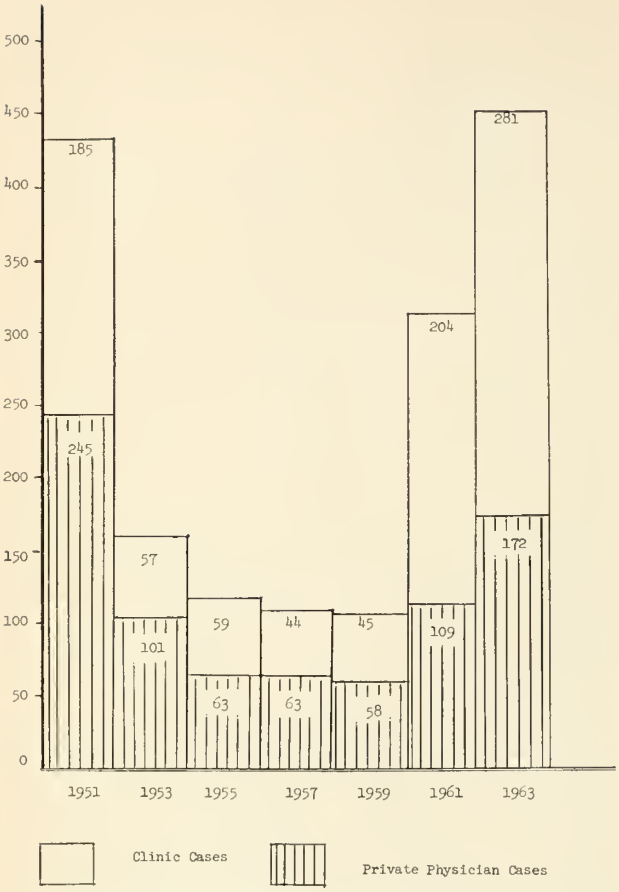

Fig. 2. Primary and secondary syphilis cases reported to Michigan Department of Health.

syphilis cases than private physicians (Fig. 2). Screening of the requests for "Special Medical Dispensation for Marriage" revealed that 20 to 30 per cent of the persons treated for syphilis were not reported to the health department. The following cases reveal further evidence of negligence in the reporting of syphilis cases:

*Case 1:* Patient W.D., whose serologic test for syphilis (STS) revealed a VDRL titre of 1:4. After the normal 15-day waiting period, a request for disposition was sent to the attending physician. The physician reported that the patient was originally diagnosed as chancroid, but since the serology was reactive, he questioned his diagnosis. The physician also requested that the health department locate the patient and refer him to his office since he had not returned for treatment. The investigation was completed in another state after the information was forwarded and W.D. was brought to treatment for syphilis.

*Case 2:* On June 12, a laboratory report revealed a reactive STS on R.P. On June 19, another reactive serology for this patient was reported which revealed a rising titre. The physician did not voluntarily send a disposition and a visit to his office revealed that the patient was under treatment for secondary syphilis; not only was the case not reported, but no attempt had been made to locate source or spread infections. The physician granted permission for the patient to be interviewed. *This interview and subsequent investigation of the contacts uncovered two additional cases of primary, one case of secondary, and six cases of early latent syphilis among the 58 persons investigated.*

*Case 3:* In another instance, a named contact to infectious syphilis had been sought by the investigator for several months, without success. He was located in December, and stated that he had been treated for syphilis in September. When asked to verify this, the physician stated that the patient was treated in September and that a darkfield examination of the lesion had been positive. The physician stated that he "just failed to report the case." No interview had been done.

Recognition of the disease and prompt reporting of diagnosed cases is the first step in the control program and is absolutely essential if we are to be successful.

It was largely because of the obvious deficiency in case reporting that the Venereal Disease Regulations were amended and became effective on May 15, 1962. Although the program is still comparatively new, the reporting of positive and reactive laboratory tests is proving to be an aid to the venereal disease control program. During the first year following the regulation, the number of cases of syphilis reported by private physicians almost doubled (from 1,997 to 3,738). At present, follow-up of laboratory reports, through the attending physician, is responsible for 30 per cent of the primary and secondary syphilis cases and 73 per cent of total syphilis cases (all stages) reported in Michigan.

## THE NEED TO FIND AND EXAMINE CONTACTS

Case reporting accomplishes nothing unless epidemiologic measures are applied. More than 97 per cent of the primary and secondary syphilis cases reported in Michigan in 1963 were interviewed by health department personnel. Only five private physicians refused permission to have their patients interviewed. This cooperation on the part of the private physican is commendable.

Because of the mobility of many syphilis patients and contacts, and the necessity for rapid follow-up of contacts, information regarding out-of-state contacts is telephoned to the proper health authorities immediately following each interview. As a result of follow-up of contacts, 166 cases of primary and secondary syphilis and 75 cases of early latent syphilis were placed under treatment in 1963.

During the past year, more than 7,000 private physicians have been visited and presented with

(*Continued on Page 28*)

# *The Story about . . .*

## Cervical Cytology Survey, Emmet and Charlevoix Counties

By

**J. H. WEBSTER, M.D., and J. R. POSTLE, M.D.**
**Both of Petoskey**

### *Introduction*

*Purpose.*—A number of cervical cytology surveys have been carried out in the State of Michigan. Of the 28 surveys including 28,935 women developed and carried out in Michigan since 1954, few have been reported for general review. We feel, therefore, that our experience in the Emmet-Charlevoix survey presents interesting and vital data which may be of interest to Michigan physicians.[1]

*Background.*—The interest in the cytological diagnosis of malignancy has steadily increased in the years since the publications by Papanicolaou and Traut.[2] The cervical smear technique has demonstrated an exceptionally reliable method to discover early cervical cancer. To the clinician this means of detecting early malignancy has many advantages of an ideal cancer test; it is simple to perform, inexpensive, and highly reliable. The usefulness of the cervical smear as listed by Gates and Warren follows:[3]

1. The study of obscure or borderline lesions which cannot be diagnosed by usual methods.
2. The determination of the success of treatment (follow-up smears).
3. A routine test for general physical examinations.
4. An adjunct to biopsy.

A distinct advantage is the possibility of multiple and repeated cytological examinations without inconvenience or discomfort to the patient.

To the cytopathologist the technique is a rigorous discipline requiring considerable time and effort. It is highly gratifying as a standardized procedure having a reliability of greater than 95 per cent in cervical smear studies.

### *Methods*

*Organization.*—Cytology surveys are programed in Michigan as an educational procedure. A purpose is to inform the female population and the practicing physician of the value and reliability of the cytology smear. Demonstration of its value as an integral part of a complete general physical examination is desired.

The survey reported here was outlined by the Michigan Department of Health to the local District III Health Office and brought to the local Medical Society for discussion and approval.[4] The local branch of the American Cancer Society acted as a third interested sponsoring agency. At a joint meeting of these sponsoring agencies, inclusive dates for the survey were determined and the pathways for publicity developed. The women were asked to make appointments with their physicians as for any office call. The physician was requested to make a general cancer screening examination to include sites as mouth, skin, breast, genitalia and obtain a cervical smear. The patient was responsible for paying for the usual office fee. If she was unable to pay the fee the cost was borne by the local welfare department if she was registered on the public assistance roster. If she was not on public assistance, but indigent, the local Cancer Society assumed responsibility for this fee.[5]

*Collecting Material.*—The physicians submitted the fixed smears to a pathologist selected by the local Medical Society and the Michigan Department of Health made specific arrangements to pay at a rate of $3.00 per case, including a report sent to the physician and a copy to the local District Health Office. The Michigan Society of Pathologists has supported organized cervical screening surveys by agreeing to supply the slide interpretation at cost.

Smears fixed in 50-50 ether-alcohol for 30 minutes were air dried and mailed to the laboratory. These were entered, stained and read along with the daily work. Artifacts due to air drying and other factors were not a problem.

A period of six weeks, March 1 to April 15, 1962, was selected. Approximately 40 physicians submitted slides to the laboratory for evaluation. In gen-

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Doctor Webster, Department of Pathology, Burns Clinic, Petoskey, and Doctor Postle, Department of Gynecology, Burns Clinic, Petoskey.

eral, the preparations were excellent with only 0.34 per cent of cases, including broken slides, unsatisfactory.

*Reporting.*—

1. Standard Classification.—The five-step classification of Papanicolaou was used, and the smears were reported with these comments:

| | |
|---|---|
| Class I: | No atypical cells present |
| Class II: | Atypical cells present, probably benign |
| Class III: | Abnormal cells present, possibly malignant |
| Class IV: | Abnormal cells present, probably malignant |
| Class V: | Malignant cells present |

The routine cytology study of two slides per patient requires from 5 to 15 minutes per case. There is some individual variation among cytologists and pathologists within the framework of the five-step classification but such variation probably does not affect significantly the final data.

2. Unclassified Atypical.—Unclassified atypical cases may require some explanation. Among this group are those smears showing endometrial cells in post-menopausal patients, always regarded as abnormal even though the cells may be benign in appearance.[6] We make no attempt to classify abnormalities of gland cells; the site is localized to endocervix or endometrium and the atypicalities described. Adenocarcinoma is apt to be better differentiated than epidermoid carcinoma, and thus may retain many of the features of the parent site; endocervix or endometrium. The probability of finding malignant cells from endometrial adenocarcinoma is much less than for epidermoid carcinoma of the cervix, hence the reliability of the examination is reduced for adenocarcinoma.

## Data

*Diagnostic.*—Table I shows the classification and representative data for a total of 1,458 patients examined in this survey.

TABLE I

| Classification | No. Cases | % Cases | Proven Carcinoma |
|---|---|---|---|
| Class I | 1,309 | 89.8% | 0 |
| Class II | 94 | 6.5% | 1 repeated as Class III with ca-in-situ |
| Class III | 30 | 2.3% | 7 proven ca-in-stiu (23%) |
| Class IV | 7 | 0.4% | 5 in-situ, 1 invasive, 1 undetermined, in-situ or invasive (100%) |
| Class V | 0 | 0.0% | 0 |
| Unclassified, atypical | 12 | 0.7% | 1 repeated Class V with invasive acanthotic ca endocervix, 1 known post-rad. ca. Follow-up Pap. Class I (neg.) |
| Unsatisfactory | 6 | 0.3% | 0 |
| Total Cases | | 1,458 | |
| Total Proven Carcinoma | | **17** | { In-situ 14 82.3% |
| New to E/C Survey | | 16 | Invasive 2 11.6% |
| % Proven Carcinoma | | 1.2 | Post radiation 1 5.8% |

*Follow-up.*—It becomes increasingly apparent that having accepted the responsibility for participating in a survey one also accepts the responsibility for follow-up of abnormal smears. No case with abnormal cells is closed without definitive follow-up and treatment. Table II shows the diag-

TABLE II. TREATMENT AND FOLLOW-UP CLASS III SMEARS
8 Cases (all in-situ)

| Case | Age | Diag. Procedure | Definitive Rx | Residual Ca | Follow-up |
|---|---|---|---|---|---|
| 1 | 34 | Conization | Abd. hyster. one tube & ovary | + | None |
| 2 | 36 | Conization | Abd. hyster. right tube & ovary | — | None |
| 3 | 38 | Conization | Vag. hysterectomy | — | Biopsy vagina neg. |
| 4 | 27 | Conization | None | undetermined | Follow-up Pap. neg. |
| 5 | 45 | Biopsy (vv) | Abd. hyster. Bilat. tubes and ovaries | | Metastatic squ. cell ca in ovarian vein. 2 follow-up Paps. neg. |
| 6 | 38 | Biopsy (neg) (oo) | Hysterectomy (ca-in-situ) | + | None |
| 7 | 33 | Conization | Abd. hyster. | — | None |
| 8 | 31 | Conization (*) | Hysterectomy | + | None |

vv Metastatic carcinoma in ovarian vein
oo Biopsy negative; hysterectomy positive
* Original Class II; follow-up Class III, 6 months later. Biopsy positive ca-in-situ

TABLE III. TREATMENT AND FOLLOW-UP CLASS IV
7 Cases (5 in-situ, 1 undetermined, 1 invasive)

| Case | Age | Diag. Procedure | Definitive Rx | Residual Ca | Follow-up |
|---|---|---|---|---|---|
| 1 | 31 | Biopsy (in-situ) | Repeat biopsy (neg.) | undetermined | Two follow-up Paps. neg. |
| 2 | 34 | Biopsy* | Abd. hyster. both tubes & ovaries | + (in-situ) | None |
| 3 | 40 | Conization (in situ) | Abd. hyster., lt. tube & ovary | — | Follow-up Pap. neg. |
| 4 | 33 | Conization (in situ) | Hysterectomy | — | None |
| 5 | 41 | Conization (in situ) | Abd. hyster. | — | None |
| 6 | 53 | Conization (in situ) | Abd. hyster. both tubes & ovaries | — | None |
| 7 | 41 | Conization (invasive) | Radium Rx | undetermined | Follow-up Pap. neg. |

*in-situ vs. invasive not determined on biopsy nostic procedures, treatment and follow-up of the Class III smears. The average age of this group of patients is 35¼ years.

Table III shows the diagnostic procedures, treatment and follow-up of the Class IV smears. The average age of this group is 39.

## Discussion

*Clinician's Evaluation of Pathologist's Report.*—The proper interpretation of the smear classification as it relates to the individual patient is to a considerable degree dependent upon close cooperation and communication between the pathologist and the clinician. The remarks concerning these interpretations, therefore, apply only to our situation and may not be generally applicable.

The Class II report presents a difficult problem in interpretation by the clinician. As shown by the data in Table I, only one of the 94 cases, to date, has been shown to have developed carcinoma of the cervix. Inflammation and epithelial atrophy probably account for most of these atypical smears. A repeat smear offers the best follow-up for these patients. This should probably be done within six months and be preceded by appropriate therapy of any existing vaginal or cervical pathology.

Follow-up of Class III smears has shown a 23 per cent incidence of carcinoma. This percentage is sufficient to warrant diagnostic D & C and conization in most of these patients. An occasional patient in this group can be screened in the office with Schiller stain and punch biopsy. If the biopsy is negative, careful follow-up cytology studies are still necessary. As in the Class II group, some of these smears will revert to normal after treatment of inflammatory or atrophic changes.

The Class IV report is almost invariably associated with a diagnosis of cervical malignancy and the diagnostic conization is performed on these patients primarily to distinguish between pre-invasive and invasive malignancy.

The unclassified smear previously mentioned requires re-evaluation of the patient's record and personal consultation with the pathologist. A clinical judgment must then be made concerning the appropriate follow-up.

*Diagnostic Procedures.*—The virtues of cold knife conization are well established. The cone should be of sufficient size to: (1) survey the entire cervix for areas of malignancy including sufficient endocervix, (2) allow sufficient cervical stroma so that the pathologist may orient his stepsections and rule out early invasive lesions or lymphatic spread within the cervix.

One case in this series had a diagnosis of in situ carcinoma by biopsy and metastasis in the ovarian vein discovered after simple hysterectomy and bilateral salpingo-oöphorectomy. Others have reported metastasis from in situ carcinoma.[7] Another patient who had a negative biopsy proved to have in situ carcinoma in her hysterectomy specimen. She is indeed fortunate that the second procedure was carried out. One can conclude that few mistakes will be made if the cervical material presented to the pathologist is adequate.

*Definitive Treatment.*—Definitive treatment for the various stages of cervical carcinoma is well established within the confines of certain accepted variations of approach. These will not be discussed in this report.

Carefully selected cases of in situ carcinoma of the cervix in young women may be followed after wide excision by conization. The only acceptable reason being the desire for further child bearing. In the potential candidates for this type of management we have found Schiller staining of the cervix at the time of conization helpful in our attempt to widely excise the entire lesion.

## Summary

1. The organizational structure and experience in a small cervical cytology survey in two counties in Northern Michigan is presented.

2. The role of the various sponsoring agencies is described.

3. The classification, breakdown and follow-up data from 1,458 patients with 17 positive cases of cervical cancer is detailed.

4. Clinical discussion regarding interpretation, diagnostic procedures, and definitive treatment is presented.

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# Partial Amputation of the Penis Without Postoperative Stricture

By **JACK LAPIDES, M.D.**

**Ann Arbor**

Stricture of the urethral meatus continues to be a common complication following partial amputation of the penis. Since the introduction of the concept of elliptical connection by Nesbit in 1949[1] and its application in partial resection of the phallus[2] no postoperative meatal strictures have been encountered at the University of Michigan Medical Center Hospitals. This report is a description of the operative technique in use at the present time.

## OPERATION

A tourniquet is applied to the penis at the penoscrotal junction and the penile skin and Colles' fascia are incised circumferentially at least 2.0 cm. proximal to the lesion (Fig. 1-A).

In order to obtain a length of one centimeter of intact distal urethra free from adjacent cavernous bodies and available for elliptical anastomosis the shaft of the penis is transected one centimeter from the neoplasm. This maneuver exposes very nicely the various components of the genital appendage so that the urethra and corpus spongiosum can be readily discerned and dissected free from the cavernous bodies without being injured for a distance of 1.0 cm. (Fig. 1-C).

After the urethra and corpus spongiosum are mobilized, the overlying corpora cavernosa are transected 1.0 cm. proximal to the new urethral orifice (Fig. 1-B, C).

The exposed ends of the corpora cavernosa are closed with several interrupted heavy silk mattress sutures taken transversely through Buck's fascia and tunica albuginea as illustrated in Figure 1-C. The suture passes from one side at the left corpus through the septum between the corpora cavernosa through the lateral side of the right corpus and then back through the corpora and fascia in a similar fashion. The urethra and corpus spongiosum are spatulated by incising them at 6 o'clock for the entire length of projecting tube (Fig. 2-D). The urethra is fixed to the corpora cavernosa with six

*(Continued on Page 28)*

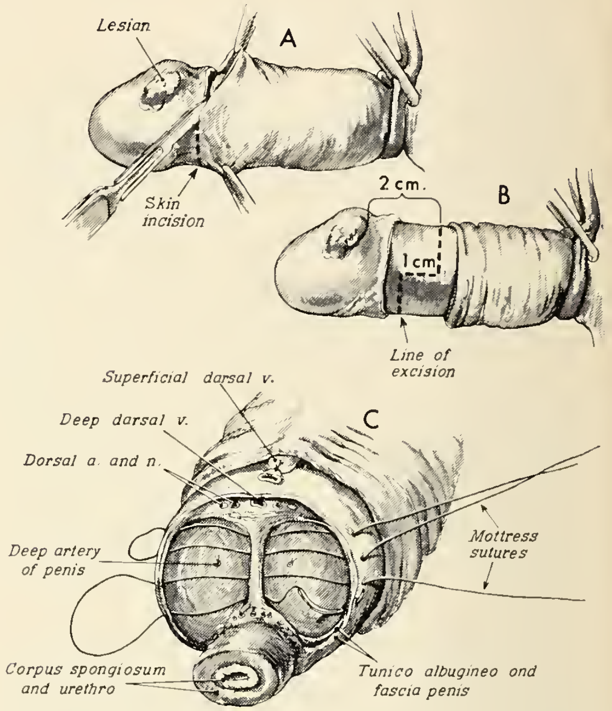

Fig. 1 *A.* With tourniquet at base of penis, skin and Colles' fascia are incised circumferentially. *B.* Corpora cavernosa are transected 2.0 cm. and the corpus spongiosum 1.0 cm. proximal to the lesion. *C.* Exposed ends of the corpora cavernosa are closed with several silk mattress sutures.

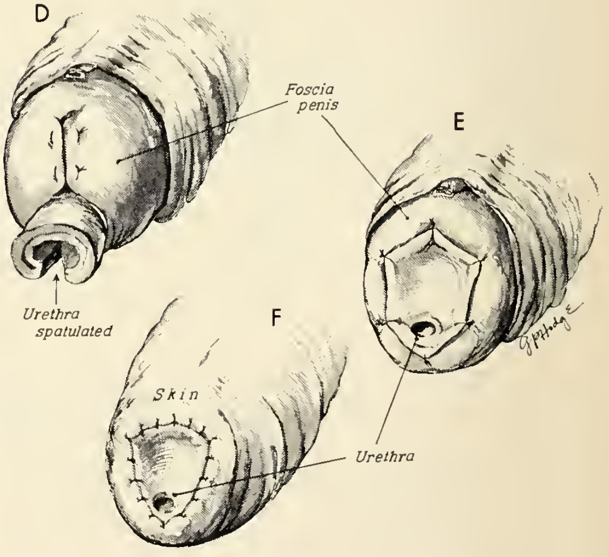

Fig. 2 *D.* Urethra is spatulated by incising at 6 o'clock. *E.* Urethra is fixed to the corpora cavernosa with interrupted catgut sutures. *F.* Operation is completed by anastomosing skin to the urethra and corpus spongiosum.

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From the Department of Surgery, Section of Urology, University of Michigan Medical School, Ann Arbor, Michigan.

# FUNCTIONING PHEOCHROMOCYTOMA WITH NEUROFIBROMATOSIS WITHOUT HYPERTENSION

**By DOUGLAS CHANDLER, M.D., F.A.C.P**
**Birmingham**

The association between pheochromocytoma and neurofibromatosis has been known and described for more than 50 years. Both functioning and nonfunctioning tumors of the chromaffin system have been reported with neurofibromatosis. The nonfunctioning neoplasm of the chromaffin cells are found at autopsy, while the functioning pheochromocytomas indicate their presence by the well-described picture produced by excessive catecholamine production and release. Hypertension is the primary sign initiating the suspicion of pheochromocytoma. This case of pheochromocytoma with von Recklinghausen's disease is presented because of the absence of elevation of diastolic pressure and with only slight elevation of systolic blood pressure during paroxysms of clinically suspected endogenous catecholamine infusions. A recent complete review of all reported cases of pheochromocytoma and neurofibromatosis reveals that at least 37 cases have been reported to 1962.[12] In all of these cases there was definite evidence of elevation of both systolic (above 200 mg. Hg.) and diastolic (above 110 mm. Hg.) blood pressure, except for one case reported by Guenther,[9] wherein the blood pressure was not obtained during any of the attacks.

## CASE REPORT

The patient is a 55-year-old, white woman, R.N., with known neurofibromatosis with a 3 months' history of sudden attacks of shaking, jitteriness, palpitations, sweating, weakness, headache, flushing and anxiety. At first the attacks lasted 10 to 15 minutes and occurred at about 2-week intervals, but soon increased in frequency and duration. The onset of a frontal headache served to warn the patient that an attack could be expected in thirty minutes. The frontal headache lasted approximately one day after the attack. Prior to her admission blood pressure was determined frequently through six attacks. At no time did the blood pressure rise over 165/80 and most of the determinations were 130-140/70-80. Attacks could be precipitated with twisting and turning of the trunk or when the patient was particularly fatigued.

The past history revealed that the patient had diptheria and myocarditis in 1928, and had pneumonia approximately ten times since 1936. Her obstetrical history was grava 2, para 0, abortus 2. A hysterectomy had been performed in 1945. Her mother died at age 54 of cancer of the uterus. Father died at age 76 with a myocardial infarction. The patient had seven siblings, two of whom had von Recklinghausen's disease as did the father. Four siblings are diabetic. The patient had been on two grains of thyroid for approximately twenty years.

Physical examination revealed a well-developed, mildly obese, white woman with multiple fibroid nodules on the skin and in the subcutaneous tissue. Many café-au-lait spots were scattered over the skin. Blood pressure was 140/70 and the lungs were clear to percussion and auscultation. Abdominal examination revealed no masses or enlarged organs. Neurological examination was normal, and the examination of the extremities was unrevealing, as was the balance of the complete physical examination.

*Hospital Course:*—Blood pressure during the hospitalization remained at 100-110 systolic over 60-70 diastolic.

A histamine test was performed on November 1, 1963, with the following results: 1. Control 122/74, immediately after injection 100/64, one minute 182/90, two minutes 180/100, three minutes 190/100, and at eight minutes 150/80. There was a reproduction of all the patient's symptoms as described in the present illness. A cold pressor test was also done with a control of 114/74, in one minute, the pressure was 130/82, and in five minutes, 114/76. On November 8, 1963, a presacral air insufflation was performed which revealed an enlarged left adrenal gland.

*Laboratory Results:*—Urine examination revealed pyuria. Hemoglobin was 12.5 grams with a white blood count of 8,100 and a normal differential

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count. Fasting blood sugar was 95 mg. BUN was 15 mg. per cent. Electrocardiogram was interpreted as normal. The six-hour glucose tolerance test was reported as follows: fasting, 81 mg.; one half hour, 118 mg.; one hour, 114 mg.; two hours, 115 mg.; three hours, 93 mg.; four hours, 75 mg.; five hours, 82 mg.; six hours, 87 mg. Vanillylmandelic acid test performed prior to the histamine test was 3.3 mg. in 24 hours (normal 0.7 to 6.8 mg. per 24 hours). Catecholamines were 34 mg. per 24 hours (normal 32 to 103 mg. per 24 hours). Vanillylmandelic acid test performed immediately after the histamine test was 1.7 mg. per 12 hours. Urine sample sent to the University of Michigan Clinic was reported as follows: total vanillylmandelic acid 0.53 mg. per 24 hours. Catecholamines 58 micrograms per 24 hours (normal 10 to 100 mg.). Paper chromatography and cellulose electrophoresis revealed no rise in total vanillylmandelic acid.

On November 14, 1963, the patient underwent a surgical exploration via an anterior abdominal approach. A 6 centimeter lobulated mass was found on the jejunal wall and excised. A second lesion, approximately 2 inches distal to the first lesion, was also removed. A tumor mass was found in the left adrenal gland which was approximately 5 to 6 centimeters in diameter. Manipulation of the mass produced a marked rise in blood pressure from 120/85 to 200/100. The patient responded very quickly to 4 mg. of Regitine given intravenously.

Pathologically, the tumor was partially cystic. The specimen was accompanied by two pink-lobed masses presumably from the jejunal wall. The latter were diagnosed microscopically as being neurilemmomas of the serosa of the jejunum. The adrenal gland weighed approximately 15 grams. There was a sharply demarcated medullary nodule that was gray-white with focal hemorrhages and a cyst at one end of the mass. On microscopic examination, this was revealed to be a cystic tumor in the medulla with large cells with giant or multiple muclei. The diagnosis of pheochromocytoma was confirmed.

## DISCUSSION

The estimation of the numerical relationship between pheochromocytoma and neurofibromatosis varies from five to twenty per cent depending on the author's series and evaluation.[1,3,5,11] Chapman et al found their incidence to be 13 per cent.[7] The latter included cases with both functioning and nonfunctioning pheochromocytomas. It is agreed that the addition of the abortive forms of neurocutaneous diseases would probably increase the percentage of pheochromocytoma found in this group. The presence of the stigmata of the neurocutaneous disease, even in the abortive form, should serve to alert the physician to the presence of pheochromocytoma in any patient with symptoms consistent with that diagnosis even without the presence of hypertension.[10] Signs such as neurofibromatosis of the eyelids or an increased number of café-au-lait spots over what ordinarily would be expected for normal would give the physician a clue for the diagnosis of pheochromacytoma. The latter is diagnosed, at the present time, in about one of 50,000 hospital admissions.[14]

The addition of other neurocutaneous disorders increases the tie between these two seemingly unrelated diseases[3] because of ectodermal origin of these organ systems embryologically. During the fourth embryonic week, the neural plate, which is a thickened portion of ectoderm, invaginates, fuses, and forms a neurotube which becomes separate from the skin. The chromaffin cells are essentially derivatives of the primitive neural crest and invade the primordial cortical mass during the seventh fetal week. They are distributed throughout the center of the adrenal gland by the end of fetal life. Thereby comes the relationship of the neurocutaneous diseases to each other and to pheochromocytoma.[1,6]

Glushien, Monsuy, and Littman[3] added the von Hippel-Lindau disease to the list of neurocutaneous disorders complicated by pheochromocytoma. Four more cases of association of these two diseases have been reported.[6,7] They predicted that tuberous sclerosis and Sturge-Weber syndrome would also show an association with tumors of the chromaffin cell. They based this prognostication on the fact that all have a cutaneous and a neurological abnormality in common. They encourage the search

### *Coming in February*

In February, watch MICHIGAN MEDICINE for important notes on "Investigation of Infertility" by Robert W. Noyes, M.D., chairman of the Department of Obstetrics and Gynecology at Vanderbilt University.

"The Michigan Department of Health Laboratories" is described in an effective paper by their director, G. D. Cummings, M.D., and there will be several interesting case studies of a varied nature.

for incomplete forms of these diseases, particularly in patients with hypertension, as a possible indicator of the presence of pheochromocytoma.

All reported cases of pheochromocytoma with neurofibromatosis have had hypertension at one time or another during the course of their medical observation. Our patient had no hypertension during her attacks and had low normal blood pressure between attacks. Gifford et al,[8] in reporting their clinical experience with 71 cases of pheochromocytoma, remarked that only one patient had no evidence of hypertension. This patient had profuse perspiration, and the catecholamine level proved to be so high that surgical exploration was carried out. A pheochromocytoma was found. All patients described as having a combination of pheochromocytoma and neurofibromatosis have had an elevation of catecholamines, either in urine or blood, or both, either during persistent elevation of blood pressure, or during a paroxysmal elevation of blood pressure, or immediately after a histamine test. Litchfield and Peart have reported one patient who excreted a normal amount of catecholamines after a histamine test as well as during a spontaneous attack. Therefore, it would be highly unusual for a patient to have pheochromocytoma and have a normal catecholamine and vanillylmandelic levels, particularly after a positive histamine test. The rise in blood pressure that the present patient developed during an attack could have been interpreted as an anxiety episode. This could have been considered within normal limits for a patient without pheochromocytoma who was going through a period of stress. Searching for an explanation for this phenomena, one might consider the fact that there is some difference in the pressor and metabolic activities of epinephrine versus norepinephrine. It is an acknowledged fact that the epinephrine is a product of norepinephrine and that it is primarily produced by the adrenal glands, whereas, the sympathetic post-ganglionic nerve endings exclusively produce norepinephrine. The ratio of epinephrine to norepinephrine produced by the adrenal medulla is approximately four to one. Epinephrine is more likely to produce metabolic effects as well as other manifestations of overactivity of the autonomic nervous system without stimulating an excessive amount of hypertension, either on a paroxysmal or a sustained basis. With the constant excretion of norepinephrine or the frequent excretion of both there is a tendency to a more paroxysmal type of hypertensive effect as well as a sustained elevation of the blood pressure.[8]

It is interesting to speculate about possible reasons for the lack of hypertensive effect in this particular patient. The hypertensive action of epinephrine and norepinephrine, when introduced exogenously, is very short lived (approximately two to four minutes). It is possible that the mechanisms which tend to inactivate and destroy the catecholamines might be overactive in this patient. There is the possibility that the amount of catecholamines that is being produced by the adrenal gland might be in small supply in view of the fact that the large portion of the gland was cystic and hemorrhagic.

Crout and Sjoerdsma[12] have recently presented a possible explanation for the discrepancy between the presence of a functioning pheochromocytoma and the absence of hypertension. They describe two groups of patients at opposite ends of an incomplete spectrum. One group of patients is associated with small tumors (under 50 grams) in which the catecholamines are replaced extremely rapidly producing a relatively pure infusion of norepinephrine and epinephrine. These patients have a high turnover rate of catecholamines at approximately 68 per cent (plus or minus 16 per cent) of the total body stores replaced each day. These patients have a large norepinephrine circulation before the tumor enlarges. In another group of patients, there is usually a large tumor (greater than 50 grams) in which the catecholamine storage turnover is extremely low, with norepinephrine and epinephrine metabolized directly in the tumor. These patients had tumors which may have escaped clinical detection until the tumor became large enough for elevated secretions of norepinephrine and epinephrine to be detected chemically and physiologically. They present the concept that the intracellular binding of the catecholamines, the regulation of catecholamine synthesis, and the activity of catecholamine degrading enzymes (monoamine oxidase and catechol-o-methyl transferases) may be abnormal in pheochromocytoma cells. This may account for the wide variations in the rate of production and release of free catecholamines and their metabolites. It is possible that the patient in the present report was in the early stage of the large-tumor, low catecholamine producing group, and therefore did not show much rise in blood pressure. Instead, she presented some of the side effects of epinephrine and norepinephrine production. This was on a transient basis. The degrading enzymes might have been working overtime, and in addition could prevent the catecholamines from stimulating a greater response.

## SUMMARY

A case report on the combination of pheochromocytoma and neurofibromatosis has been presented. The unusual features of this particular case consist of the absence of hypertension, even during paroxysmal episodes, and the absence of elevated catecholamines or vanillylmandelic acid before or after histamine stimulation. The physician

should be alerted to the presence of pheochromocytoma in all patients with the abortive or full blown neurocutaneous syndrome, especially in the presence of hypertension or symptoms of catecholamine release.

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## CONTINUED: WHY DON'T WE CONTROL SYPHILIS?

*(Continued from Page 20)*

information about the venereal diseases. In many areas of the state venereal disease educational programs are getting underway in schools and other segments of the community. Screening programs, including premarital and prenatal blood testing, industrial blood testing, routine blood testing on hospital admissions, are all a necessary part of the control program.

The various elements of the program are interrelated and each dependent upon the other for total success. Epidemiology is dependent upon reporting; reporting upon diagnosis; public awareness upon education and information, etc. Similarly, public health agencies are dependent upon private physicians and vice versa. Our understanding of and the fulfillment of our respective roles in this endeavor will eventually determine our success or failure.

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## CONTINUED: PARTIAL AMPUTATION OF THE PENIS

*(Continued from Page 24)*

interrupted 2-0 chromic catgut sutures (Fig. 2-E). The operation is completed by anastomosing the skin to the urethra with interrupted 4-0 plastic nonabsorbable sutures (Fig. 2-F). An inlying urethral catheter is unnecesary postoperatively.

### SUMMARY

An operative technique for partial amputation of the penis is described. The procedure is based on Nesbit's concept of elliptical anastomosis and is devoid of the postoperative complication of meatal stenosis.

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## FROM THE FLINT JOURNAL

*(Excerpts from Editorial: "SS HOPE Sets Sail Again as U. S. Goodwill Symbol")*

"It doesn't seem to be overstating the potential to point out that some of the most effective tools in the world today as far as international understanding is concerned can be found in the field of health.

"In this field, the SS Hope is fulfilling its role as an impressive symbol in the far corners of the world of the good will of Americans. It is helping to demonstrate in a most practical way that imaginative private foreign aid can be tremendously effective, and that individual Americans are willing to finance it."

# "Blurring of the Mirror"

**By E. C. SWANSON, M.D.**
**Vassar**

Much has been written and said about the "Public Image of the Medical Profession." The Federation of State Medical Boards of the United States has selected this subject as its general theme for the program this year.

There have been and still are many factors which tend to "blur" the public image of the medical profession. These factors originate from "outside" and also from "inside" the group.

In order to gather some data regarding this topic I obtained some facts from three (3) different surveys. Two of these were conducted by the office of the Michigan State Board of Registration in Medicine and one was conducted by Ben Goffin Associates of Chicago, Illinois.

## Survey No. I

A questionnaire was sent from our office in Lansing, Michigan, to each Secretary of the fifty State Boards of Medical Examiners. It contained the following:

*SUBJECT:* The "Bad" Public Image of the Medical Profession

*REASONS WHY:* ?

*HOW CAN THE IMAGE BE IMPROVED:* ?

I realized that this was a loaded question, but I wanted some answers. Of the fifty questionnaires sent out I received about forty replies.

Under the "Reasons Why" included those:
(a). Outside the Profession and
(b). Inside the Profession

### OUTSIDE THE PROFESSION

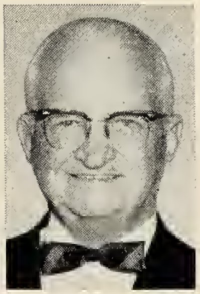
1. The adverse propaganda released to the press
2. High costs of drugs
3. Medical quackery
4. Insidious pressure by the Federal Government in an attempt to control the Profession
5. Insidious pressure by Hate groups and individuals to discredit the Profession

### INSIDE THE PROFESSION

1. Unavailability of the physician
2. Physicians complain, criticize, and condemn their colleagues and their work
3. Physicians charge varying fees for identical services in the same locality
4. Physicians spend too little time with patients
5. Recent medical school graduates lack background concerning the history and heritage of the Profession
6. General practitioners are harder to find; more physicians are specializing
7. The "Art of Medicine" has been lost or else it is not taught
8. Physicians are reluctant to testify in court against colleagues whom they know to be unethical and unreliable
9. Physicians avoid accepting their responsibilities as citizens
10. Large medical groups are split on basic aims of the American Medical Association
11. Private agencies and medical groups are endeavoring to usurp the legal duties of the Federation of Medical Examiners

### HOW CAN THE "IMAGE" BE IMPROVED?

1. The physician has two roles to play in his community, namely, to render the best health care possible and also to accept his obligation as a citizen by becoming interested and active in civic, religious, educational, and youth programs
2. His fees should be reasonable
3. He should always be available and reliable
4. He should diligently strive to improve his medical knowledge and skill; and assiduously review the history and heritage of his profession
5. He should live by the Oath of Hippocrates and by the Code of Ethics of the American Medical Association
6. He should also improve his association and communication with his colleagues



Author
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M.D.

## Survey No. II

This Survey was conducted by Ben Goffin Associates of Chicago and consisted of a recent "Public Opinion Poll" as to "What Americans Think" about Doctors. It included the questioning of 3,000 members of the general public, 500 physicians in private practice, and 100 persons each of special groups—such as editors, columnists and commentators, lawyers, pharmacists, registered nurses, and executive secretaries of state and county medical societies.

The results of Survey No. II can be summarized briefly:

1. People almost universally like and respect their personal or family physician
2. A doctor is more critical of doctors than the public is
3. The public tends to emphasize the traditional concepts of the family doctor
4. Neither the public nor most doctors are very critical of the AMA's political activities
5. Doctors call for closer ties with individual physicians and further improvement of public relations
6. The press, attorneys, and druggists have less favorable attitudes toward doctors and organized medicine than has the public

Better public relations by the profession would improve the attitudes of the above groups.

## Survey No. III

About one year ago, I was invited by the President of a Pre-Medic Club of one of our large State Universities to present a program at one of their regular meetings. I inquired as to what types of programs they usually had previously enjoyed and was informed that for the past three meetings they had viewed colored movies shown by local M.D.s. These films included, Caeserian Sections, brain operations, and heart surgery. I thought that this seemed rather odd for Pre-Medic students some of which were only Freshmen in College so I decided on a different approach.

When the meeting was called to order I requested that each member provide himself with some blank paper and a pencil or pen as I was about to ask them to write down five questions and to give me their honest answers. They were instructed not to place their names on the papers, as I thought that this would afford them an opportunity to furnish perfectly frank answers.

### QUESTIONS ASKED

1. Why do you want to study medicine?
2. Do you want to be a general practitioner or a specialist?
3. How much money do you expect to earn in the practice of medicine?
4. In how large a community would you like to practice medicine? Why?
5. When do you expect to purchase your first Cadillac? Why?

After the members of the audience indicated that they had answered all the questions the papers were collected. The questions and answers were then discussed.

### ANSWERS

About 80 per cent of the group seemed to be looking at the practice of medicine as one would view the merchandise behind the window pane at Tiffany's. They wanted to be specialists, live in communities of at least 25,000 population so they could have better hospital facilities and make more money. About 45 per cent of the group expected to buy their first Cadillac as soon as possible even though it had to be purchased on time payments because they believed that the driving of a Cadillac gave them prestige in the community.

The Oath of Hippocrates and the Code of Ethics was then explained to them. They were advised that the practice of medicine affords excellent opportunities for rendering service to their fellow man and that this should be the prime motivating factor in having them study medicine.

Now why should the youth of this country have such a twisted attitude about the practice of medicine? It is not entirely the fault of our young people.

People today are subjected to superb mass communication media, superb advertising every day on T.V., radio, newspapers, etc. The message goes something like this: "Do not deny yourself. Do not hold back. You owe it to yourself to have a new car, a new house, etc. Only a few dollars down and a few cents a week gets you these things. Everybody is doing it. Why shouldn't you?"

### PRESSURE GROUPS

During the past twenty years external and internal forces have attempted and with some success, to socialize the basic institutions of this nation. They have centered their attentions on the medical profession, but they cannot stop here if they are to accomplish their task. The Wagner-Murray-Dingell Bill, Forand Bill, and King-Anderson Bill are excellent examples of the manner in which socialism is at work in Washington, D. C. These Bills were designed for the greedy, not the needy.

An attempt is being made to divide and conquer the various citizens groups of the public and the profession. It behooves every physician to tell the public in his respective area the truth. This threat is not to medicine alone, but to America.

The insidious forces use a chosen emotional appeal for each group of citizens. They do not tell the general public the truth.

These pressure groups and interests do not distinguish facts from rumors, truths from allegations, and reality from propaganda.

Their powerful organizations are geared to promise material gains for the individual which he thinks he can not obtain by himself. They project themselves as agents of the individual, doing collectively what they say cannot be done nearly so well by the isolated individual acting alone. The organizations often serve to aggrandize their own leaders, oftentimes at the expense of the membership. They claim to speak and act for the individual members. Sometimes the members in many cases have not been consulted. Thus the organizations tend more and more to speak for man in the mass thus crushing his individuality and personal responsibility through the organizations' power and voice.

Our greatness as a nation and as a people lies in keeping on course toward still greater individual initiative, individual freedom, and individual responsibility, the only course that leads ultimately to the total security we all so much desire.

Doctor Drolett, a friend of mine who happens to be of French extraction, stated in one of his talks about Medicare.

"There is an old story that says you can't kill a frog by dropping him into boiling water. He reacts so quickly to the sudden heat that he jumps out before he is hurt. But if you put him in cold water and then warm him up gradually, he never decides to jump until it's too late. By then he is cooked."

Men are just as foolish. Take away their freedom overnight and you have a violent revolution. But steal it from them bit by bit (under the guise of "security," "peace," or "progress") and you can paralyze an entire generation. Look at the income tax. It started out at a harmless 1%. It would have been easy to jump out of the tepid water then, but like the frog, we waited until the tax climbed higher. Try jumping now.

Worst of all, we never learn. Even today many cannot believe that Medicare is the same warm water that may one day boil us in "Socialized Medicine." Some see no connection between farm price supports and Nationalized Agriculture. And if we draw a parallel between subsidized teacher's pay and federal control of education, we are called "extremists."

The tragedies of history are always repeated by those who refuse to learn from them. To seek guidance from the past is "not turning the clock back" as we are often told. It is merely a good way to keep out of hot water.

## LEADERSHIP

There is one thing which is resented by those who attempt to control the different groups of citizens—physicians included. That is Leadership—The Oath of Hippocrates and the Code of Ethics when properly understood develops leadership in the physician. They reveal how physicians should feel about each other, will do for each other, and also that they are willing to fight for each other. It is upon these ideals that the survival of the profession rests.

Some say that in a democracy there is no need for the Oath and a Code of Ethics. Some go so far as to say that leadership is incompatible with democracy. Others say that in a democracy no one is going to tell them what to do.

Insidious forces are attempting to control the profession by attacking its leaders. They object to leadership in their enemies. They say the profession is undemocratic because it refuses to compromise. They say that they are discriminated against. We are not supposed to take prejudiced points of view. We are told to be open minded. We sometimes teach this to our children. Many times because of this teaching we stand for nothing, fight for nothing, and work for nothing. We must all take a stand and tell the true story of medicine. No group in America reaches so many people as does the medical profession.

## GRATITUDE FOR OUR HERITAGE

We do not seem to emphasize our medical heritage any more. Any profession is cowardly when it no longer wants to study its own history. How can anyone really understand the profession without a knowledge of the many sacrifices that made that profession great?

We read in the newspapers about "Your Baby" and how to properly immunize and care for it against diseases.

The medical students (professional infants) and the recent graduates should likewise be immunized against the insidious forces which they will eventually have to contend with.

The obligations inherent in assuming the honor of being a physician should be taught in the medical schools.

The world is in a state of evolution and revolution, and the doctor must be cognizant of this fact and adopt his professional life and practice to the new and perplexing problems he encounters daily in the new age which we are pioneering.

Walter Lippman writes that there has developed a functional derangement of the relationship between the mass of people and the government. The mass of people have acquired power which they are incapable of exercising and the government officials they elect have lost powers which they must recover if they are to govern.

## MEDICAL EDUCATION

The recruitment of qualified students is a crucial problem confronting the Admissions Committees of our Medical Schools. The mass education of doctors and licensing in large numbers alone, whether American or foreign, will not solve the health needs of this country. These needs can only be met by intensive preparation of physicians which emphasizes high competence and the pursuit of excellence.

The freedom of the individual doctor must be preserved in the present complex of expanding activities. The proper education of physicians is one of the most important investments that a nation can make.

The most effective organization in American Medicine could be the modern medical center, providing it affords the ideal climate for education. It should perform the function of creating an environment in which students of diversified interests have or develop a sense of responsibility for patients which should be the sole motivating factor of the physician.

## SPECIALIZATION

Specialization is a necessity of modern civilization but we must retain the concept of the patient as an individual and the family as the basic and valuable unit of society. A physician must be first and always a physician, having in mind the entire human being—not simply one organ or system, to which he devotes most of his attention.

## RESEARCH

Research should be kept in balance with teaching and patient care. It is not necessary to reduce scientific inquiry, but merely to strengthen the support of teaching and patient care.

## INDOCTRINATION INTO MEDICAL SOCIETY

Medical Societies should provide a program of indoctrination for those physicians who make application for membership. All new members should be required to attend a series of lectures defining the purposes and functions of the local, state, and national medical groups. They should be instructed relative to the Oath and the Code of Ethics of the profession.

They should also learn about the importance of their Society membership and their medical license. They should be compelled to attend a certain number of society meetings annually in order to maintain their membership.

## COOPERATION AND SUPPORT

The future status of our profession will largely be determined by the constant cooperation and concentrated effort of everyone concerned. Medicine was founded on the principles that physicians should learn from each other and share in each others trials. It seems reasonable that we must reach a state where it will be natural and desirable to engage in a relationship embracing every aspect of human existence. Without cooperation and friendship there is a sickness in the profession that affects all of us.

Stephen Grellet stated many years ago something which applies to the medical profession when he said, "I shall not pass through this world but once, Any good therefore that I can do, or any kindness I can show to any fellow creature, let me do it now. Let me not defer or neglect it, for I shall not pass this way again."

## CONCLUSION

We are engaged in a conflict with groups within this organization and also insidious forces outside of the profession. We cannot underestimate our enemies.

It is fitting and proper that this profession should remain as a single unit—under the guidance and direction of the American Medical Association which advocates the teaching and practice of medicine according to the Oath and the Code of Ethics.

Edmund Burke once stated, "The only thing necessary for the triumph of evil is that good men do nothing." Cooperation and active support must be rendered by all concerned.

In closing I would like to quote a few words from a talk given by Frank Tait, former Chairman of General Dynamics.

"We must awaken again within ourselves, that hot war urgency that has always been our salvation in the past. The threat today is subtle, and difficult to conquer. We must attack it with the weapons of understanding and hard work. These are difficult concepts to sell in a democracy. They cannot be encapsulated in a slogan. They cannot be depicted in a poster. But they are our only hope for survival. It is this hot war urgency and these ancient principles upon which this great moral experiment of the American Government was founded."

We must retain the idea that men are individually responsible and that responsibility is a predictable quality in men, also

That there is a right and there is a wrong. These qualities underlie the successful solution of any problem.

Presidential Address, Federation of State Medical Boards of the United States, Chicago, Illinois, February 10, 1964.

## C. E. Umphrey, M.D. MSMS Past President Dies at 68

Clarence E. Umphrey, M.D., a past president of both the Michigan State Medical Society and the Wayne County Medical Society, died December 11, in Birmingham. He was 68 years old.

Doctor Umphrey practiced 38 years in Wayne County and had made his residence in Birmingham since 1956.

A 1925 graduate of Wayne State University School of Medicine, Doctor Umphrey interned at Receiving Hospital. He was a Fellow of the American College of Surgeons and the International College of Surgeons.

Long active in medical society affairs, Doctor Umphrey was a former member of the MSMS Council, and also a former member of the Wayne County Medical Society Council and Board of Trustees. He also had served as Wayne Society secretary.

Doctor Umphrey was a life member of the Michigan State Medical Society.

*(Details about his year as President of MSMS are contained in the MSMS Centennial article on page 37.)*

## Editor Writes

"Medicaritis: As one who falls into the 'over 65' category, I can well understand the appeal of 'Medicare' to our senior citizens.

"Yet the politicians who are pushing this legislation seem to be suffering from 'medicaritis.' They tell what the proposed bill will do, but say little of what it will not do.

"The Congress should move slowly on this measure and investigate alternative methods including insurance coverage at lower cost by spreading the risks."

JOHN S. KNIGHT
*Detroit Free Press*

# MSMS Promoted at Miami AMA Votes to Stand Firm

The Michigan State Medical Society building, publication activities were promoted by Michigan delegates at the AMA Clinical Convention at Miami. The MSMS headquarters suite utilized the functional MSMS exhibit that is used at the Annual Session and other activities.

Delegates from other states were impressed with photos of the headquarters, the improved *Michigan Medicine,* the new Centennial seal, etc.

### *Michigan Resolutions Introduced*

MSMS delegates introduced two resolutions dealing with medical care for the aging. The AMA House voted to "stand firm" against compulsory hospital-medical program under Social Security. The AMA House also voted "unequivocal approval" of an expanded educational effort to explain Kerr-Mills and warn the nation about the dangers of the Administration's Fedicare plan.

The MSMS delegation at Miami was led by W. A. Hyland, M.D., Grand Rapids, as Chairman, and included G. W. Slagle, M.D., Battle Creek; D. N. Sweeny, Jr., M.D., Detroit; J. R. Heidenreich, M.D., Daggett; O. J. Johnson, M.D., Bay City; and L. R. Leader, M.D., Birmingham. Alternate Delegates were E. E. Martmer, M.D., Grosse Pointe; R. E. Rice, M.D., Greenville; Sidney Adler, M.D., Detroit; G. B. Saltonstall, M.D., Charlevoix; B. M. Harris, M.D., Ypsilanti; and Otto K. Engelke, M.D., Ann Arbor.

### *Elect Pennsylvania Physician*

The Delegates paid tribute to the late Norman A. Welch, M.D., AMA President, who died on September 3.

James Z. Appel, M.D., of Lancaster, Pa., Vice Chairman of the AMA Board of Trustees, was named President-Elect. He will become President in June, 1965, succeeding Donovan F. Ward, M.D., of Dubuque, Iowa.

### *Tele-typewriter Network Voted*

The AMA House approved a recommendation of the Board of Trustees to establish a tele-typewriter communications service between the AMA and the state medical societies.

It is hoped that the new communications system will become operative no later than July 1965. The system will provide automatic and uninterrupted communications between AMA headquarters and all participating state societies, and also between the state societies. Installation and rental costs will be paid by AMA.

## To Each Member . . .

A questionnaire, of considerable importance to Michigan Medicine, appears on Page 52-A.

Each member is urged to fill it in, remove it from the journal, and mail it today to MSMS.

"Michigan Medicine" is a member of the State Medical Journal Advertising Bureau, Chicago, and all member journals are carrying such a questionnaire in their January issues.

Read pages 52-A and 52-B for further details.

# *Health Council Elects*

S. D. Steiner, M.D., Detroit, is the new President of the Michigan Health Council, and Richard U. Byerrum, Ph.D., East Lansing, is the President-Elect.

The Michigan Health Council held its annual meeting in East Lansing, December 9, to hear progress reports and to select officers and directors.

Doctor Steiner, medical director of General Motors, succeeds Earle A. Irvin, M.D., Grosse Pointe, as President for 1965.

Professor Byerrum, who has been a member of the Board, is the Dean of Natural Science at Michigan State University and will lead the organization during 1966.

Andrew Pattullo, Director of the Division of Hospitals, W. K. Kellogg Foundation, Battle Creek, was chosen as the new Treasurer, and Executive Director John A. Doherty was renamed Assistant Treasurer. Re-elected as Secretary was Hugh W. Brenneman, MSMS Executive Director.

J. K. Altland, M.D., Associate Commissioner and Director of Medical Services of the Michigan Department of Health, was re-appointed as Medical Advisor, and Lester P. Dodd, M.D., Detroit, was re-named Legal Counsel.

Chosen as new members of the Board of Directors were Harry A. Towsley, M.D., Ann Arbor, President of the American Academy of Pediatrics, and Arthur Clements, Dearborn, Assistant Secretary of Michigan Medical Service.

S. D. Steiner, M.D.

R. U. Byerrum, Ph.D.

# Detroit News Aids Ten State Medical Students

DETROIT—The Detroit News Medical Aid Fund has selected 10 medical students for $500 grants. In the fifth year of activity, the Detroit News program assists medical students in their second or third years.

The five WSU students are Susan Adelman, May-Siang Lim, Theodore Rights, Dominic Losacco and James Collins; and the U-M students were Douglas H. Hildreth, Donald G. Dimcheff, David A. Ekland, James M. Roberts and Richard L. Zuelke.

The grants were made through the deans of the two Michigan medical schools.

**A letter from any member will obtain from MSMS a supply of Emergency Medical Identification cards for their patients. MSMS also offers an education brochure for the office. Just write to MSMS, Box 152, East Lansing.**

# FDA Enforces Prescription Drug Advertising Law

The Food and Drug Administration has started enforcing the prescription drug advertising provisions of the new Kefauver-Harris law.

The law requires that prescription drug advertisements show:

The "established name" of the drug, if one exists, in type at least half as large as that used for the brand name;

The drug's quantitive formula, and

A true and non-misleading brief summary of information about adverse side effects, contraindications, and effectiveness of the drug for the guidance of physicians.

Joseph F. Sadusk, Jr., M.D., Medical Director of FDA, said that it is the duty of physicians to keep fully informed of the composition, mode of action, efficacy and potential toxicity of drugs because as the potency of drugs increases, "so generally does their complexity and their potentiality for harm."

In enforcing these requirements, FDA will seek to determine whether a fair balance exists between the information on effectiveness and that on side effects and contraindications.

The FDA's Bureau of Medicine has started monitoring professional journal advertising for prescription drugs. It will forward violative advertisements with appropriate recommendations to the FDA Bureau of Regulatory Compliance.

The American Medical Association has notified the American Pharmaceutical Association that the AMA Judicial Council had adopted the following opinion:

> **"It is unethical for physicians to use prescription blanks with the name of the pharmacy printed thereon."**

In an accompanying letter to APhA, William J. McAulliffe, Jr., Director, AMA Department of Medical Ethics, said "We will very much appreciate your assistance in eliminating this practice."

Among the leaders at the Cancer Day activities in Detroit, December 14, were, (seated left to right) Donald H. Kaump, M.D., Sidney Farber, M.D., and Oscar D. Stryker, M.D.; standing, (left to right) Brock E. Brush, M.D., and Kenneth Endicott, M.D.

# *Milton A. Darling Research Center for Cancer Dedicated*

"Only a handful" of such units as the new Milton A. Darling Memorial Center exist in the world.

That evaluation was made by Kenneth Endicott, M.D., Director of the National Cancer Institute, in his remarks at the dedication of the Darling Center at Grace Hospital, December 14. The Center, clinical division of the Detroit Institute of Cancer Research, was made possible by an original grant of $1,177,215 from the U. S. Public Health Service.

During the Center dedication, Donald H. Kaump, M.D., Ann Arbor, president of the DICR, paid tribute to Doctor Darling. "Doctor Darling," he said, "played a particularly vital role in the accomplishments of the Grace Hospital and his county and state medical societies. Other tributes were paid by Roger W. DeBusk, M.D., hospital administrator. Others participating in the program included William L. Simpson, M.D., DICR Scientific Director; C. P. Anderson, M.D., Deputy City Health Director; Gordon H. Scott, Ph.D., Vice-President for medical development of Wayne State University; and Oscar E. Stryker, M.D., Mt. Clemens, outgoing President of the Michigan Cancer Foundation.

Following the dedication, the Michigan Cancer Foundation held its annual dinner meeting at the Wayne County Medical Society building where Sidney Farber, M.D., of Boston, Director Children's Cancer Research Foundation, spoke.

Brock E. Brush, M.D., Detroit, was elected as the new President of MCF and C. F. Arnold, Detroit, was re-elected Chairman of the board. James C. Cook, M.D., Detroit, was elected Vice President and Chairman of the medical scientific committee.

Trustees re-elected included Doctor Cook; James D. Fryfogle, M.D., Southfield; Rosser L. Mainwaring, M.D., Dearborn; Lyndle R. Martin, M.D., Detroit; and Donald N. Sweeny, Jr., M.D., Detroit.

In other related elections, Herman J. Linn, M.D., Royal Oak, succeeds Michael J. Brennan, M.D., Grosse Pointe, as Chairman of the board of trustees of the Michigan Cancer Registry.

Gerald S. Wilson, M.D., Detroit, became President of the Cancer Detection Center, succeeding E. Eric Muirhead, M.D., Detroit.

## Next Hearing In Detroit on Blues' Request

Another hearing will be held in Detroit January 7 and 8 by State Insurance Commissioner Allen L. Mayerson on the request of Blue Cross-Blue Shield to adopt merit rating.

Commissioner Mayerson presided at the hearing held in Lansing, December 15, where spokesmen for various organizations spoke on behalf of the request or against it. Reasons for the proposed change were outlined by Blue Shield President Sidney Adler, M.D., and by Blue Cross Vice President-General Manager Bennett J. McCarthy.

At the Lansing hearings, the point was clarified that merit rating, as requested by the Blues, falls between experience rating and community rating. It also was made clear that the Blues intend under the merit rating request to continue a degree of subsidy for senior citizens.

Doctor Adler, in his comments, declared, "We do not anticipate any change in the MMS senior citizen rates for at least 2 years."

## Doctor Howell, New Ford Hospital Executive

James T. Howell, M.D., began duties January 1 as the Executive Director of Henry Ford Hospital, succeeding Robin C. Buerki, M.D.

Doctor Buerki retired after 13 years as the executive and will continue to serve as a consultant and trustee.

Doctor Howell, who has spent all his medical career at Ford since 1944, was assistant administrator for 9 years.

# AMA Readies Educational Effort

AMA spokesmen who addressed representatives from the state medical societies at a workshop in Chicago, December 13, declared *"Now is a crucial time for the medical profession and those we serve—we need to face the issues with concern, conviction and courage."*

The workshop, which had been announced at the AMA meeting in Miami, was held to provide up-to-date, accurate information to state society representatives and to seek advice for the development of an educational effort. The expanded educational program was voted *"unequivocal approval"* by the AMA House of Delegates in Miami.

The next step in the AMA plan was a meeting December 20 of the AMA Board of Trustees, with key commissions to develop the details.

Also projected will be another workshop in Chicago, January 9, when AMA leaders and state medical society leaders confer on legislative aspects of Kerr-Mills improvement.

MSMS was represented at the Chicago meeting by Robert J. Mason, M.D., Birmingham, Vice-Chairman of The MSMS Council, and Hugh W. Brenneman and Herbert A. Auer of the MSMS staff. Robert G. Combs, M.D., Ingham County Medical Society public relations chairman, was a guest.

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# Pick Three For "Health Hall of Fame"

Three Michigan citizens have been selected for the Michigan Health Council's "Hall of Fame in Health."

An announcement December 16 revealed the three selections "for outstanding contributions:"

Homer H. Stryker, M.D., Kalamazoo, orthopedic surgeon and inventor, honored in 1963 by MSMS with a "Certificate of Commendation."

Reuben L. Kahn, Sc.D., professor emeritus at the University of Michigan, recognized for the Kahn Test and innumerable medical achievements.

Miss Emilie Sargent, R.N., who retired this year as executive director of the Visiting Nurses Association of Detroit.

A total of 12 Michigan citizens now have been named to the "Hall of Fame in Health."

CHICAGO—Physicians must assume leadership in helping develop sound medical criteria for driver licensing, declared U. S. Public Health Surgeon General Luther L. Terry, M.D., at the AMA Conference on Medical Aspects of Driver Safety and Driver Licensing.

John R. Rodger, M.D., Chairman of the MSMS Committee, represented MSMS. Several other Michigan physicians also were present.

## Dr. McLean to Lead WSU Fund Board

DETROIT—MSMS Councilor Don W. McLean, M.D., Lathrup Village, is the new chairman of the Wayne State University Fund board of directors. A past president of the Wayne County Medical Society, and chairman of the MSMS Health Fair for 1966, Doctor McLean is a graduate of the WSU School of Medicine.

The Fund, created in 1954, encourages alumni gifts towards scholarships, faculty research, and other activities.

# In Brief:

CONSTANTINE—The St. Joseph County Medical Society and Auxiliary recently held their third annual benefit dinner for AMA-ERF. Dr. and Mrs. Charles Zimont were hosts at their Constantine home for the dinner prepared by the Auxiliary members. Those attending paid what a similar restaurant meal would cost. The proceeds were sent to the AMA-ERF to aid deserving students.

* * *

DETROIT — The Detroit Sinai Hospital Department of Phsychiatry Rotating Lecture Series in January and February will present Morris Weiss, M.D., Detroit. The series, Wednesday nights at 7:30, continues through February 24.

# '65 Congress of Professions Themes Chosen

The 1965 Congress of the Professions, March 26-27 in Grand Rapids, will develop a dual theme of "Relationships—Old and New" and "The Professional Portfolio of Services."

The 6th Annual Congress will be held at the Pantlind Hotel with attendance open to all members of MSMS and the seven other professions represented in MAP.

The Friday theme, March 26, will involve a consideration of relationships between the professions; relationships between the professions and third parties (business, labor, government); relationships with other nations; and relationships with ancillary personnel and suppliers.

The Saturday session, March 27, will consider how well the professions are meeting changing needs with services.

The Annual Meeting will be held on the morning of March 26.

LANSING—Three physicians have been appointed to the new Michigan Human Resources Council by Governor Romney. Among those named were Albert E. Heustis, M.D., State Commissioner of Health; Robert A. Kimmich, M.D., Director, State Department of Mental Health, and Myron E. Wegman, M.D., Ann Arbor.

# MSMS Centennial Series: 1951, 1952

## *Funds Contributed for Beaumont Memorial*

**This article in the MSMS Centennial Series was written prior to the death of C. E. Umphrey, Past President during 1950-51. Doctor Umphrey died December 11. The obituary appears on Page 33.**

### *1951*

In doing the spade work for the history of MSMS, we sent letters to all the living Presidents. The answers were few. However, Past President C. E. Umphrey, M.D., Detroit, did write a letter which I think is worth printing. It gives his idea of his contribution as President of the MSMS for 1951.

> *"If I was of particular value to the MSMS, that value probably was directed toward our medico-economic and medico-legal problems. In most of my articles and president's messages these problems were ever uppermost in my thinking. If these articles and papers were collected in one book they would not depict a pleasant picture for a bureaucratic Washington.*
>
> *My very best wishes,*
> C. E. UMPHREY, M.D.

As you read the rest of this year's story, you will see that he did an excellent job.

* * *

MSMS PRESENTED a scroll of appreciation to the Woman's Auxiliary on the occasion of its 25th anniversary in September, 1951 at the MSMS Annual Session. The various county auxiliaries had as their important projects, the sponsorship of Cancer Detection Centers, and assistance to Easter Seals for the Michigan Society for Crippled Children, Red Cross work and the Red Cross Blood Donor Program, Nurses Recruitment Program, Cerebral Palsy Clinics, public meetings on mental hygiene, and study groups for medical legislation and numerous other projects.

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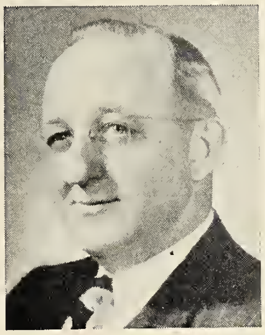
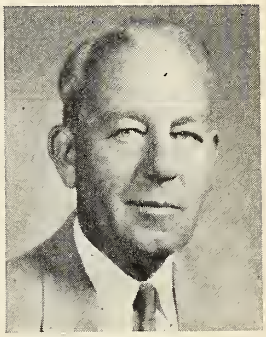
*Leading up to the MSMS Centennial in 1965,* THE JOURNAL *is printing a series of articles by William J. Stapleton, Jr., M.D., Detroit, who is the MSMS Historian. This series began in the September, 1963, number of* THE JOURNAL *and will continue through August, 1965.*

*The Author*

WILLIAM J. STAPLETON, JR.
M.D.
MSMS Historian



C. E. Umphrey, M.D.
MSMS President, 1950-51



Otto O. Beck, M.D.
MSMS President, 1951-52

The State Auxiliary's projects then included Student Loan Fund, promotion of Hygeia Magazine, Collecting of Medical and Surgical Relief Supplies, promoting and sponsoring the Tuberculosis Speaking Project, promotion of Blue Cross-Blue Shield Voluntary Insurance Plans, and the promoting of the Medical Associates Program.

* * *

THE COUNCIL, at its mid-summer meeting talked to W. F. Doyle, Chairman of the Mackinac Island State Park Commission, and then decided to start immediate promotional work on architecture and contracting plans for the restoration of the Early House as a Beaumont Memorial on Mackinac Island.

Authorization for the purchase of 606 Townsend Street, Lansing, was given by The Council on July 5. Remodeling work on the first MSMS headquarters building began that fall.

The recommendations of Editor Wilfrid Haughey, M.D., were approved to provide special notation on the covers of all 1951 issues of the Journal to indicate the "Golden Anniversary of the Journal."

An invitational membership campaign was started at the Annual County Secretaries-Public Relations Conference. The Public Relations Department developed a brochure setting forth the benefits of membership in the AMA, The MSMS, and the component County Medical Societies.

The 1951 Annual Session in Grand Rapids featured the premiere on the new MSMS film "To Save Your Life."

* * *

THE HOUSE OF DELEGATES resolved that the Old American Fur Company store on Mackinac Island be restored as a memorial to William Beaumont, M.D. Contribution of $10 from each member was encouraged.

The Michigan Rheumatic Fever Control Program was established (and has been continued under the major premise that the family physician is the central figure of the program). It is a highly specialized undertaking whereby both physician and patient understand the total problem of the disease: the care, education, rehabilitation, and job placement within the capabilities of the individual patient's heart.

Frank N. Wilson, M.D., Professor of Medicine at the University of Michigan, considered one of the nation's foremost exponents of the rational understanding of the electrocardiogram, received the Gold Heart Award of the American Heart Association in Atlantic City.

A long-range plan for cooperation with the adult education system of Michigan in the purveying of health information to the people participating in adult education classes was presented and approved in December.

## *1952*

The MSMS plans to restore the Beaumont Memorial on Mackinac Island really moved forward in 1952 under Doctor Beck. In January, the Council, upon the recommendation of Finance Chairman W. S. Jones, M.D., transferred $1,000 from a recent $5,000 Parke Davis contribution to the Beaumont Memorial Trustee Fund to begin preliminary work. A County Secretaries-Public Relations Seminar in January heard an appeal for funds made by Doctor Beck.

A replica of the proposed building was shown at the Michigan Clinical Institute in Detroit; the exhibit manned by the Auxiliary and Medical Assistants Society.

Contributions by August had reached $20,689, more than one-half of the goal of $40,000. Major contributors during 1952 was the Genesee County Medical Society with $1,864 raised by its members, and the $500 gift from the Woman's Auxiliary to the Wayne County Medical Society.

A loyalty pledge of allegiance was given in April by members of the Executive Committee of The Council, as enrollees in the Civil Defense effort.

A contribution of $600 to the Woman's Auxiliary for expenses of its Detroit convention in September, 1952 was authorized, together with a vote of commendation to the Woman's Auxiliary for its fine work and effort in the MSMS campaigns.

* * *

TEMPORARY ANNUAL licenses to Canadian graduates who are not citizens, as authorized by the Michigan State Board of Registration in Medicine at its June 12 meeting, was reported. This is pursuant to amendments made by the 1952 Legislature to the Medical Practice Act.

The 1952 Michigan Legislature amended the Basic Science Act. Briefly, the amendments to the Act will permit the Basic Science Board to approve those applicants who have successfully passed the Basic Science examinations in practically any other state; interns and residents will be exempt from taking Basic Science examination; subjects, successfully passed, need not be taken again.

* * *

THE PROBLEM OF over-utilization of hospital services for non-emergency cases, especially patients having Blue Cross-Blue Shield contracts, was presented by Michigan Hospital Service Executive Vice President William S. McNary at the March Council meeting.

At the September session of The Council, President Beck offered a report on the 1951 survey of the hospital and medical facilities of the State Prison of Southern Michigan at Jackson. This re-survey (the first was made four years ago) indicated a great improvement in health facilities at the Jackson prison. The Committee recommended additional improvements in the service.

In June, The Council was concerned about the city-operated General Hospital of Bay City, which had always been staffed by doctors of medicine of Bay City and environs. On June 9, 1952, members of the Bay City Commission voted 5-4 to allow osteopaths to practice in the hospital. This action forced out the medical staff of 70 doctors since associated activities with cultists is considered unethical by the AMA. Within one week the number of patients at the hospital dwindled to 32 as doctors brought their patients to other hospitals in the area. On June 16, the City Commission reversed itself, again by a vote of 5-4.

* * *

THOUSANDS OF PERSONS not eligible for Blue Cross-Blue Shield through a group were able to obtain hospital and surgical coverage on an individual basis during a statewide enrollment period set July 1-25, 1952. This non-group, direct enrollment program, which provides many of the benefits of group enrollment, was initiated on a statewide basis last September, when 75,000 persons enrolled.

Support of the Rheumatic Fever Control Program of the MSMS has been one of the major contributions of the Michigan Heart Association ever since the MHA's inception in 1949. The program has been in existence since 1945, starting as an activity of the Preventive Medicine Committee (later, of the Rheumatic Fever Control Committee) of the MSMS and financed by the contributions from the Michigan Society for Crippled Children and Adults, Inc., (Easter Seals), and the Arthritis and Rheumatism Foundation, Michigan Chapter. From 1949 onward, the Michigan Heart Association has assumed the major share of support. The Rheumatic Fever Control Program of the MSMS in cooperation with its component county medical societies, continues to progress and develop. This

*(Continued on Page 40)*

# LOMOTIL®

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride . . . . . . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . . . . . . . . . . . . 0.025 mg.

- lowers motility promptly
- relieves spasm promptly
- stops diarrhea promptly

Lomotil fulfills the first order of treatment in most patients with diarrhea — prompt symptomatic control.

Pending discovery of the cause, early cessation of diarrhea is almost always urgently indicated. Prompt symptomatic control averts distress, dehydration and, frequently, severe exhaustion.

Both experimental and clinical evidence indicates that Lomotil exerts such control efficiently, safely and with maximal promptness.

## dosage:

The recommended initial *adult* dosage is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is controlled. Maintenance dosage may be as low as two tablets daily. *Children's* daily dosage (in divided doses) varies from 3 mg. for a child of 3 to 6 months, to 10 mg. for one 8 to 12 years of age.

## cautions and side effects:

Lomotil is an exempt narcotic; its abuse liability is low and comparable to that of codeine. Recommended dosages should not be exceeded. Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

**SEARLE**
*Research in the Service of Medicine*

## CONTINUED: CENTENNIAL SERIES

(Continued from Page 38)

pioneering project remains the only rheumatic fever control program sponsored and organized by a state medical society on a statewide basis among all of the 48 states.

* * *

THE MICHIGAN FOUNDATION for Medical and Health Education co-sponsored the Michigan Rural Health Conference at University of Michigan. There were 94 co-sponsors including the University of Michigan and the Michigan Health Council. More than 15 County Medical Societies sent delegates.

Arch Walls, M.D., Detroit, Chairman of the MSMS Public Relations Committee, welcomed 191 registrants at the 1952 County Secretaries-Public Relations Conference held in Detroit, January 27, 1952.

MSMS at the 6th Annual Michigan Clinical Institute presented a Certificate of Commendation to the Hillsdale County Medical Society for its pioneering effort in developing the Hillsdale Plan for Tumor Detection, a practical and effective plan for finding cancer in early and curable stages.

The Michigan Health Council Board of Directors acted in June to create the position of a fulltime field secretary. The Board felt that such a person is necessary to serve better the communities throughout the state having local health councils and to expand further the Michigan Health Council and Community Health Council activities.

"Homecoming" featured the 54th meeting of the Upper Peninsula Medical Society at Iron Mountain on June 27-28. All speakers were former Upper Peninsula men who had gone out into the world to gain success in their chosen field of medical practice.

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# Describes "Fever" in Saginaw in 1822

*(The following article about medical practice in Michigan in 1922 is excerpted with the permission of the author from "Indians 'Jacks, and Pines," by Stuart D. Gross, Saginaw News education editor. The history of Saginaw, illustrated by Ralph A. Misiak and Samuel Carter, Jr., is used as a reference text for the Saginaw Public Schools.)*

"Summer evenings in Michigan today can be made troublesome by mosquitoes. Imagine what it was like in 1822! The mosquitoes bred by the millions in the swampy land along the river, and there was no protection against them. At night a person might hide his head under a blanket, but on a hot night this was almost as unbearable as the mosquito's sting.

"The mosquitoes infected the soldiers with malaria, then termed 'ague,' or merely the 'fever.' Soon reports were reaching Detroit that the Saginaw fort was an unhealthy location. This report arrived at a time when men of wealth were eyeing the wilderness around Saginaw as a likely spot for development of a town.

* * *

"MANY MEN WERE BUSY BUYING land and selling it to easterners who wanted to move to the frontier. These businessmen feared that reports of sickness at Saginaw might frighten off their prospective land buyers. So the reports were concealed, and the Saginaw area continued to be advertised as a healthy place to build a new life.

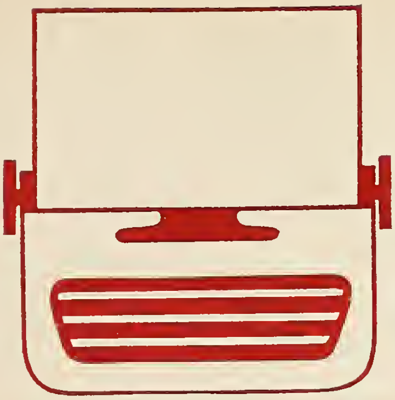
"THIS 'FLOURISHING VILLAGE' flourished only in the minds of those businessmen who had land to sell.

* * *

"DR. JOHN L. WHITING of Detroit went to Fort Saginaw in answer to the plea for medical help. He found the fort's regular physician, Dr. Pitcher, so ill he had to be carried to the bedside of his patients. Even Dr. Whiting came down with the fever after spending three weeks at the fort.

"The order to abandon the fort was signed Sept. 16, 1823, and sent from Headquarters on Governor's Island, New York, by Indian runner. The orders reached Fort Saginaw in October, and on Oct. 26 the soldiers boarded a ship on Saginaw River and sailed for Detroit. Saginaw's days as a military outpost were at an end.

"The fever the soldiers suffered was not a fatal one. There were two deaths at the fort during the year, but these resulted from typhoid fever. Although settlers also suffered from the malarial fever, the sickness was not bad enough to drive them out of the Saginaw Valley."



# EDITORIAL VIEWS

## The New Look

This January number of Michigan Medicine is the seventh to appear under this title and with the new format. There have been many compliments about our New Look, with a new cover, new layout devices, and new typography. The change was not all made with the July 1st issue, but changes have gone on since that time and, with the approval of the membership, will continue. The President's Page, rearranged slightly in October, has earned considerable attention. Doctor McGillicuddy's October President's Page about "How Will You Feel on November 4th?" received national attention when 800 reprints were ordered for distribution to key AMPAC leaders across the nation.

Over the last seven months, you may have noted progressive use of abstracts of scientific articles and, whenever possible, photographs of the authors.

The "Hot News" color section in the center of Michigan Medicine is most unusual in a publication of this type. A page is being used each month to list new members of the Michigan State Medical Society and you may have noted a growing use of Letters to the Editor.

Greater support of Michigan State Medical Society projects, such as the Emergency Identification Symbol, and Community Health Week, has been given and signed guest editorials appear with increasing frequency.

Each month a boxed story appears to tell you what scientific articles may be seen in the next issue.

Thirty-four of the State Medical Society Journals have worked together for some years in an organization called The State Medical Journal Advertising Bureau which seeks to sell advertising in all of the journals. That bureau is now in the midst of an advertising campaign and Michigan Medicine is proud to have been first to be asked to supply 100 copies of its journal to be used across the nation as an example of the type of publication in which advertisers might display their product.

Advertising in last month's November journal totaled 41 pages and was the highest number of advertising pages for 1964. It is our hope and belief that this represents the end of a long and gradual decline in advertising revenue occurring over the last several years.

The members of the Publication Committee, the Scientific Editor and the Managing Editor sincerely appreciate the many words of encouragement and support given to us by members of the Michigan State Medical Society.

We believe that we have seen seven months of progressive improvement and dedicate ourselves to a continuation of this effort.

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## A Year for Action

"Members of the medical profession MUST present a united front. There may be no tomorrow. We do have today. We must decide what we want most in life, and then act immediately if we are to obtain it. The President of the United States, the Department of Health, Education and Welfare, and those members of Congress who favor medical care under social security have announced their all-out efforts to pass the King-Anderson bill this year. Is this what you want? If it is, do nothing and you shall surely have it; if not, act at once to defeat it."

—Max E. Johnson, M.D., President,
Texas Medical Association

Your patients will say
"The Pain Is Gone"
when you prescribe

---

'EMPIRIN'® COMPOUND
with CODEINE gr. 1/2

100
'EMPIRIN'®
Compound ℞
with
Codeine Phosphate, No. 3
Each tablet contains
Codeine Phosphate (32.4 mg.) gr. 1/2
Warning.—May Be Habit Forming
Phenacetin gr. 2-1/2
Aspirin gr. 3-1/2
Caffeine gr. 1/2
3
CAUTION.—Federal law prohibits dispensing without prescription.
Usual Dose: as needed
KEEP COOL AND DRY
1808
BURROUGHS WELLCOME & CO.
(U.S.A.) Inc., Tuckahoe, N.Y.
Made in U.S.A.

'EMPIRIN' COMPOUND with CODEINE gr. 1/2 (No. 3)
KEEPS THE PROMISE OF PAIN RELIEF

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

# MSMS Maternal Conference Lists Michigan Medics

In addition to noted authorities from New York, Massachusetts and Illinois, Michigan physicians also will present addresses at the 1965 Conference on Maternal and Perinatal Welfare. The Conference will be at Flint, March 11-12, sponsored by the MSMS Committee on Maternal Health and The Clare Elizabeth Fund of Flint.

Wm. W. Jack, M.D., Grand Rapids, Chairman of the MSMS Committee on Maternal Health, reports the tentative program will include addresses by A. James French, M.D., Ann Arbor, on "Perinatal Pathology Quiz;" Charles S. Stevenson, M.D., Detroit, "Death from Infection;" Philip J. Howard, M.D., Detroit, "Some Aspects of Infection in the Newborn;" Robert O. Blood, M.D., Ann Arbor, "A Sociological Perspective on Voluntary Sterilization;" and George W. Morley, M.D., Ann Arbor, "Fifteen-Year Study of Breech Delivery in the University of Michigan Medical Center."

Michigan physicians appointed to serve as chairmen and discussion leaders include T. N. Evans, M.D., Ann Arbor; Clarence E. Toshach, M.D., Saginaw; Goldie B. Corneliuson, M.D., Lansing and Herman A. Ziel, M.D., Lansing.

MSMS President Oliver B. McGillicuddy, M.D., Lansing; Genesee County Medical Society President Lawrence G. Bateman, M.D., Flint, and MSMS Council Chairman Harold H. Hiscock, M.D., will participate in the opening luncheon, March 11.

Full information is available from the MSMS Committee on Maternal Health, Box 152, East Lansing.

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MSMS Historian **William J. Stapleton, Jr., M.D.,** Detroit, recently received a special citation from the Wayne State University College of Pharmacy for his contributions to the field of health sciences. Doctor Stapleton is a 1902 graduate of the WSU School of Medicine.

**OUR STATE SOCIETY**

OFFICE OF CIVIL DEFENSE
RADIATION DETECTION EQUIPMENT

Discussing civil defense equipment during the Grand Trunk-Canadian National Railway demonstration were, left to right, Grant L. Otis, M.D., Jackson; Benjamin Stockwell, M.D., GT chief surgeon; Donald W. Hughes, supervisor, Civil Defense Section, Michigan Public Service Commission; Max L. Lichter, M.D., Melvindale; E. C. Swanson, M.D., Lansing, and C. P. Anderson, M.D., Detroit.

## MSMS Representatives Join In Train CD Exhibit

MSMS representatives participated in a recent civil defense demonstration in Lansing by the Michigan Emergency Transport Board. Medical leaders and representatives from various state governmental, transportation and law enforcement bodies toured specially-equipped Grand Trunk-Canadian National railway cars.

The Michigan Emergency Transport Board, operating under the Michigan Public Service Commission, was organized in 1962 "from an awareness of the fact that serious problems would exist in the operation of the transportation industry in the event of a disaster, nuclear accident or enemy attack."

Representatives at the ceremony were assured that "continuing progress is being made in organizing all modes of transportation to assure coordinated action if the need arises."

During the Lansing project, MSMS President Oliver B. McGillicuddy sent a message to Montreal via the American Radio Relay League.

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### Represents MSMS

MSMS was represented at the AMA Conference on Blood and Blood Banking in Chicago by L. W. Walker, M.D., Lansing, Chairman of the MSMS Committee on Blood Banks. The AMA meeting sought "to motivate the medical profession to evaluate and implement blood banking requirements and to participate generally in local blood banking affairs."

# Abstract of MSMS Council Action

*Meeting of October 28, 1964*

### DIABETES DETECTION PROGRAM AGREEMENT

The proposed Diabetes Detection Program Agreement was referred to the MSMS Diabetes Committee for study and recommendation to the Council at its December meeting.

### REPORT OF MICHIGAN MEDICAL SERVICE

MMS President, Sidney Adler, M.D., presented a report dealing with the National Association of Blue Shield Plans, anti-duplication clauses for non-group contracts, study of coverage for care and rehabilitation institutions, and change in Michigan Medical Service executive administration.

### QUESTION RE MSMS LIFE MEMBERSHIP

The Council requested its County Societies Committee to study and advise on the problem confronting component societies when MSMS confers Life Membership on an MSMS member who is not eligible for Life Membership according to the bylaws of the component society.

### MATTERS REFERRED BY THE 1964 HOUSE OF DELEGATES

Vice Speaker Hayes reported 12 items which were referred by the House to The Council for action.

### MSMS RECOMMENDATION TO GOVERNOR'S COMMITTEE

The Council complimented Harold F. Falls, M.D., on the preparation of this fine report outlining MSMS comments on some 20 recommendations contained in the 1962 Bowles Commission report, which had been requested by the "Governor's Action Committee on Health Care."

### LIAISON COMMITTEE BETWEEN MSMS AND MHS

The Council was informed that Michigan Hospital Service had approved the creation of the Liaison Committee with MSMS. Appointments to the Committee will be announced later.

### APPOINTMENTS TO COUNCIL COMMITTEES

Chairman Harold H. Hiscock, M.D., reviewed his proposed appointments to Council committees and, with additional suggestions made by members of The Council, the proposed committee memberships were approved.

### NEGOTIATION OF NEW SCHEDULE FOR "HOME TOWN CARE PROGRAM"

The Council requested the Committee on Medicare to negotiate a new fee schedule with the V.A.

### 1965 ANNUAL SESSION ARRANGEMENTS CHAIRMAN

President McGillicuddy announced that he would appoint C. Allen Payne, M.D., Grand Rapids, as General Chairman of Arrangements for the 1965 Centennial Annual Session. In addition, Doctor Payne will serve as Chairman of the Centennial Advisory Committee.

### MSMS REPRESENTATIVE TO COUNCIL ON ECONOMIC EDUCATION

The Council authorized that Harold F. Falls, M.D., be requested to serve as MSMS representative to the Michigan Council on Economic Education.

### REPORT ON COMMUNITY HEALTH WEEK PROGRAM AND "GET OUT THE VOTE" CAMPAIGN

Executive Director Brenneman reported on these two successful campaigns.

### ENLARGEMENT OF ADVISORY COMMITTEE OF PAST PRESIDENTS

The Council approved a recommendation of the Advisory Committee of Past Presidents, requesting that the Committee be enlarged to include past Chairman of the Council and past Speakers of the MSMS House of Delegates. The Council referred this recommendation to the MSMS Constitution and Bylaws Committee.

### ADVERTISEMENT RE MD PLACEMENT

The Council authorized one ad in "The New Physician" regarding Michigan MD Placement Program.

### PUBLICATION OF BROCHURE ABOUT MAA PROGRAM

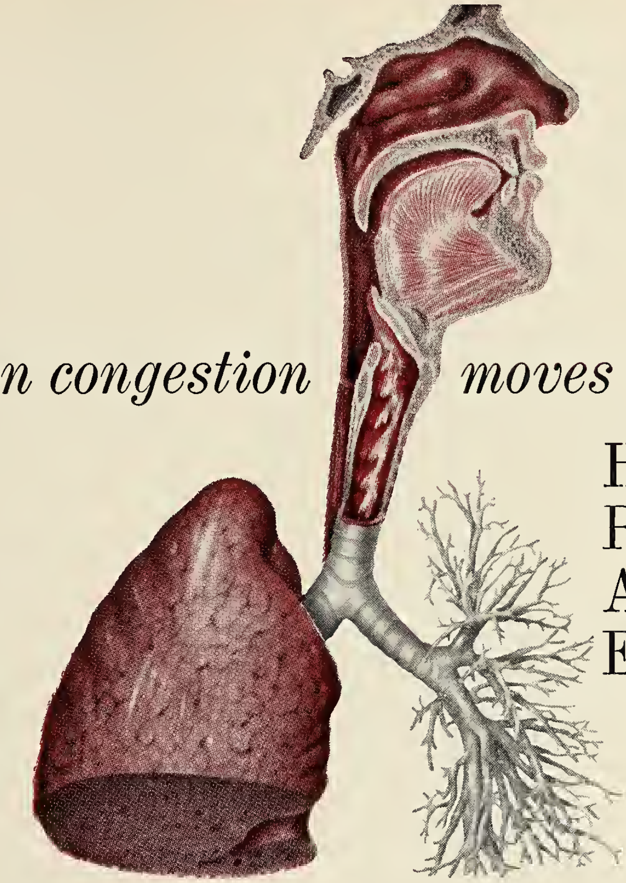
The Council approved a publication project for the printing of a Michigan Medical Aid to the Aged brochure for distribution to interested component societies.

### DISASTER MEDICAL CARE

The Council adopted a committee recommendation that "MSMS look with favor on the Michigan Department of Health workshop approach to civil defense emergency training, and do whatever possible to encourage wide participation by the medical profession and auxiliary personnel in such workshops."

### IODIZED SALT CAMPAIGN

The Council received a verbal report from the Iodized Salt Committee made by Brock E. Brush, M.D., Chairman. They approved the formation of a project committee, a statement of endorsement from the Michigan State Medical Society re iodized salt; also, authorized the development of a full campaign to the Michigan public encouraging the use of iodized salt.



*when congestion moves down*

HOME
REMEDIES
ARE NOT
ENOUGH

HYCOMINE®
SYRUP

Each teaspoonful (5 cc.) contains:

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|---|---|---|
| Hycodan® | | |
| Hydrocodone bitartrate | 5 mg. | 6.5 mg. |
| (Warning: May be habit-forming) | | |
| Homatropine methylbromide | 1.5 mg. | |
| Pyrilamine maleate | | 12.5 mg. |
| Phenylephrine hydrochloride | | 10 mg. |
| Ammonium chloride | | 60 mg. |
| Sodium citrate | | 85 mg. |

(with methylparaben 0.13% and propylparaben 0.02% as preservatives)

*in a highly palatable cherry-flavored vehicle*

treats the multiple symptoms of the COUGH/COLD syndrome

• arrests both productive and nonproductive cough • decongests the airways • liquefies secretions responsible for irritation • provides prompt symptomatic relief of allergic symptoms • is well tolerated • rarely causes constipation

DOSAGE: *Average adult dose*—1 teaspoonful after meals and at bedtime with food. *Children 6-12 years,* ½ teaspoonful; *3-6 years,* ¼ teaspoonful; *1-3 years,* 10 drops; *6 months to 1 year,* 5 drops. Administer after meals and at bedtime with food. **On oral Rx where state laws permit.**

CAUTION: Should be used with caution in patients with known idiosyncrasies to phenylephrine hydrochloride and in those with moderate or severe hypertension, hyperthyroidism or advanced arteriosclerosis. In these patients the use should not exceed three days. Hycomine* Syrup is generally well tolerated but in some patients drowsiness, dizziness or nausea may occur.

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## Doctors Appear On Michigan TV Programs

Physicians appeared on six television programs during December, offered by the Michigan Association of the Professions and the Michigan Health Council.

The joint MAP-MHC "Decisions" program over WJBK-TV, Detroit, featured Henry J. VandenBerg, Jr., M.D., Chairman, MSMS Committee on Cancer Control and Chairman, Michigan Council on Smoking and Health.

The MAP program, over WJIM-TV, Lansing, dealt with "Formula for the Whole Man" on December 19 with Rev. Dr. Paul B. McCleave, Director, AMA Department of Medicine and Religion; Richard L. Rapport, M.D., Flint, Chairman, MSMS Committee of Medicine and Religion, and William B. Betts, M.D., Grand Rapids, member of the Committee; and on December 26, "Formula for Blood" program used J. H. Venier, M.D., Lansing.

The Michigan Health Council helps with the "Shirley Clark Show" over WZZM-TV in Grand Rapids and offered Daniel Reardon, M.D., Grand Rapids, on a program about the Poison Anti-Dote Kit. Over the "Accent" program on WWTV and WWUP-TV, the MHC presented Louis F. Hayes, M.D., Gaylord, MSMS Vice-Speaker, about "Emergency Medical Identification." C. Allen Payne, M.D., MSMS Councilor, appeared on a special program over WWTV about medical quackery.

## *Please Read Pages 52A, 52B*

As the result of experiences of our sales director and staff in New York, it is considered urgent that all member journals assist the Bureau in producing a readership study.

Our sales staff has advised us that such a readership study is being urgently requested by important prospective advertisers, and also by some of our present advertisers.

We are asking each state medical journal to print a suggested questionnaire and tabulate the results for us.

Frank B. Ramsey, M.D., *President*
State Medical Journal Advertising
Bureau, Inc., Chicago

(Note: Such a questionnaire-opinionnaire appears on Pages 52A and 52B, and MSMS urges each member to fill it in immediately and return it to MSMS.)

### *Quoted*

Kansas City physicians read some of the details about the Michigan coordinated home care program in the November 29 issue of "Greater Kansas City Medical Bulletin." Their journal quoted from Michigan Medicine, 63:511, 1964.

## MEET THE MEMBERS OF THE NEW MSMS COUNCIL

*Front row* (l. to r.)—D. Bruce Wiley, M.D.; Ross V. Taylor, M.D.; Robert J. Mason, M.D.; James J. Lightbody, M.D.; Oliver B. McGillicuddy, M.D.; Harold H. Hiscock, M.D.; Luther R. Leader, M.D.; Orlen J. Johnson, M.D.; C. Allen Payne, M.D.; Bradley M. Harris, M.D.; Louis F. Hayes, M.D.

*Second row* (l. to r.)—Brooker L. Masters, M.D.; Don Marshall, M.D.; A. Carl Stander, M.D.; Robert K. Whiteley, M.D.; Don W. McLean, M.D.; Wyman C. C. Cole, Sr., M.D.; Edgar E. Martmer, M.D.

*Back row* (l. to r.)—Robert V. Daugharty, M.D.; James R. Dehlin, M.D.; John J. Coury, M.D.; Harvey C. Hansen, M.D.; Edward H. Rodda, M.D.

Not pictured—William A. Hyland, M.D.; Edward J. Tallant, M.D.; D. Roemer Smith, M.D.

**FOR YOUR ELDERLY ARTHRITIC PATIENTS...**

an effective
**GERIATRIC**
antiarthritic
with
**REASSURING SAFETY FACTORS**

Effectiveness, dependability and reassuring Safety Factors make PABALATE-SF a logical choice for antiarthritic therapy in elderly patients—even when osteoporosis, hypertension, edema, peptic ulcer, cardiac damage, latent chronic infection and other common geriatric conditions are present. The potassium salts of PABALATE-SF cannot contribute to sodium retention...the enteric coating assures gastric tolerance...and clinical experience shows that this preparation does not precipitate the serious reactions often associated with corticosteroids or pyrazolone derivatives.

Side Effects: Occasionally, mild salicylism may occur, but it responds readily to adjustment of dosage. Precaution: In the presence of severe renal impairment, care should be taken to avoid accumulation of salicylate and PABA. Contraindicated: An hypersensitivity to any component.

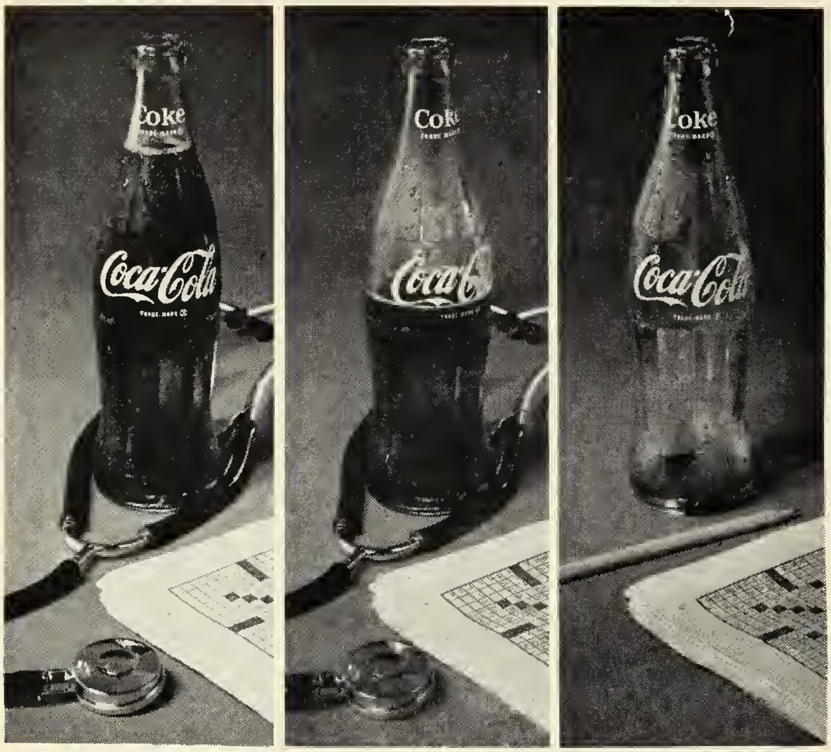
*Also available:* PABALATE—when sodium salts are permissible. PABALATE-HC—Pabalate-SF with hydrocortisone.

**Pabalate-SF**

A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA

In each persian-rose enteric-coated tablet: potassium salicylate 0.3 Gm., potassium aminobenzoate 0.3 Gm., ascorbic acid 50.0 mg.

***—the new, convenient way to prescribe***
PABALATE-SODIUM FREE



**11:47 pm** **11:53 pm** **12:06 am**

The meaningful pause. The energy it gives. The bright little lift. Coca-Cola with its never too sweet taste, refreshes best. Helps people meet the stress of the busy hours. This is why we say **things go better with Coke**

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### Calhoun Clinic Day

More than 200 physicians and surgeons participated in the Second Annual Southwestern Michigan Clinic Day program at Battle Creek.

The event, which invited osteopaths to attend for the first time, was sponsored by the Calhoun County Medical Society with the cooperation of the county societies in Eaton and Branch counties.

Outstanding medical authorities from Michigan, Ohio, Illinois, Massachusetts and Minnesota spoke. The seven guest speakers and F. Mason Sones, M.D., Cleveland, the dinner speaker, joined in roundtable discussions with local doctors before the dinner meeting.

# COUNTY SOCIETIES

## *Publish Medical History Of Muskegon County*

An important addition during 1964 to Michigan medical history is the recent publication of a booklet "Medical History of Muskegon County" by William M. LeFevre, M.D., former MSMS Councilor and now MSMS Assistant Historian.

The 60-page booklet was published under the auspices of the Muskegon County Medical Society. The booklet publication traces medicine in the western Michigan county since 1849 when Charles P. McSherry, M.D., arrived in the Port City when there were only 300 people there.

As MSMS nears its Centennial observance, the State Society encourages all county medical societies to activate its efforts to compile historic information. Hand-in-hand with the MSMS observance during 1965-66, the county societies will be able to focus the historic spotlight on local accomplishments.

### Grand Traverse-Leelanau-Benzie

The Grand Traverse-Leelanau-Benzie County Medical Society recently heard E. Freeman Hersey, M.D., chief medical examiner in Kalamazoo County and also director of the Kalamazoo County Health Department.

The three counties began using the medical examiner system on January 1.

### Midland Lectures

A series of lectures on health problems was presented recently by the Midland County Medical Society, Midland County Council on Aging and the school's continuing education department. The sessions were open to the public and held Tuesday nights at the high school. The speakers included E. H. Meisel, M.D., on rehabilitation and strokes; R. P. Grand, M.D., on genito-urinary disorders; M. J. Ittner, M.D., on gastrointestinal disorders; and H. A. Kwast, M.D., on circulatory and blood disorders.

### Ingham Survey

The Ingham County Medical Society made a survey of their members on the question of smoking and found that 149 of the respondents said they did not smoke and 116 said they did. When asked if "have you stopped?"—45 replied that they had stopped smoking since 1960.

### Jackson Career Booklet

A comprehensive loose-leaf notebook of medical and para-medical career information for use in the schools has been compiled and printed by the Jackson County Medical Society and its Woman's Auxiliary Health Careers Recruitment Committee. Information is presented on 17 careers, including details about training facilities, scholarships, loans, grants, et cetera.

### Sanilac Project

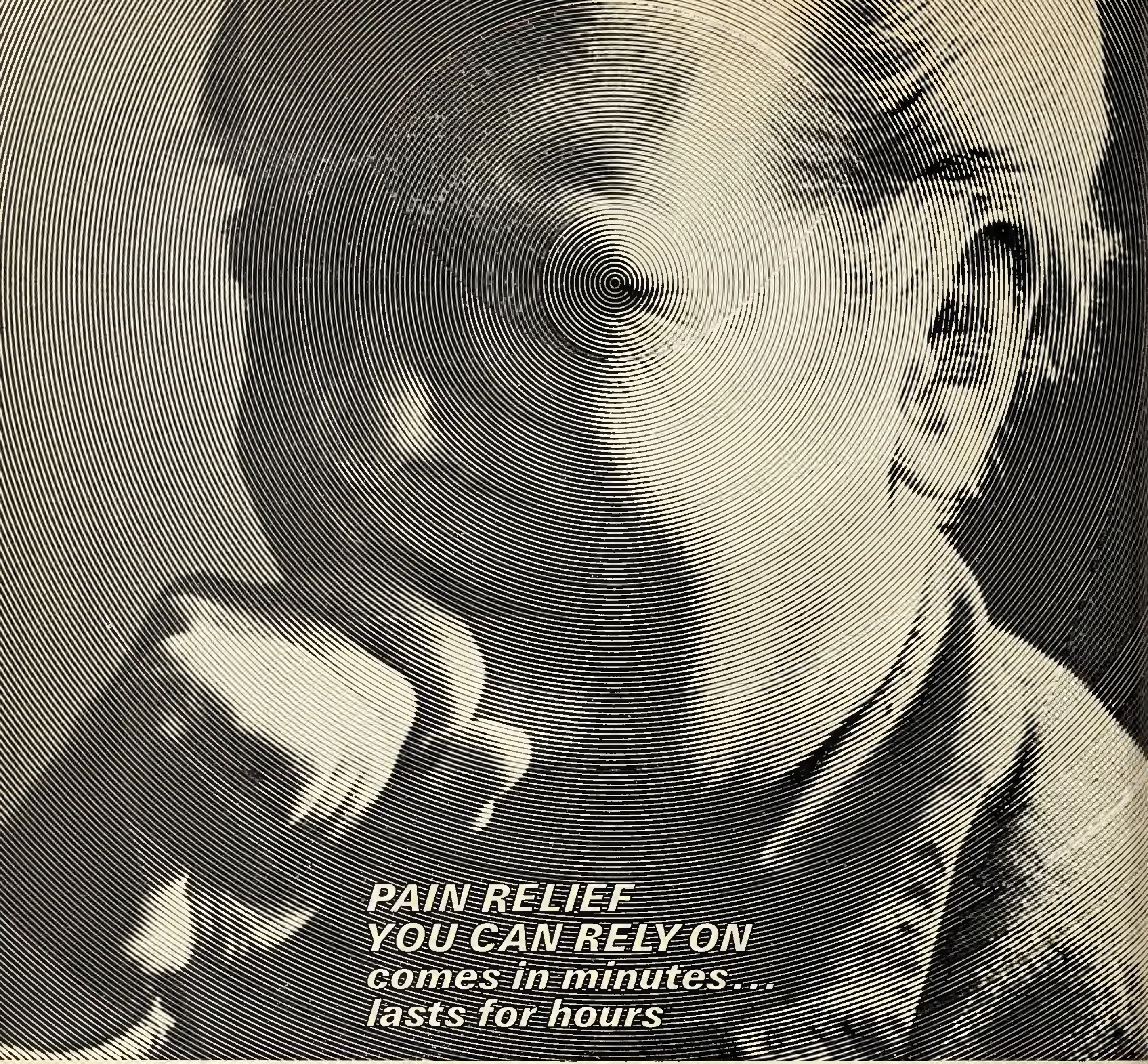
The Sanilac County Medical Society presented a film about venereal disease, "Dance Little Children," to the students and PTA groups at Brown City recently. The film was produced by the U. S. Public Health Service.

### Joint Shiawassee Effort

The Shiawassee County Medical Society joined with the Jaycees for a Diabetes Detection Drive. Phillip J. Moore, M.D., Owosso, was chairman.

### *Did You Know . . .*

. . . That John G. Milliken, M.D., Traverse City, is the brother of William G. Milliken, who is the new Lieutenant Governor of Michigan?



**PERCODAN®** | *in moderate to moderately severe pain...*

Each scored yellow PERCODAN* Tablet contains 4.50 mg. oxycodone hydrochloride (Warning: May be habit-forming), 0.38 mg. oxycodone terephthalate (Warning: May be habit-forming), 0.38 mg. homatropine terephthalate, 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine.

Throughout the wide middle range of pain PERCODAN assures speed, duration, and depth of analgesia by the oral route plus the reliability that counts so much. PERCODAN acts within 5 to 15 minutes...usually provides *uninterrupted* relief for *6* hours or longer with just *1* tablet...rarely causes constipation.

**Average Adult Dose**—1 tablet every 6 hours. **Precautions, Side Effects and Contraindications**—The habit-forming potentialities of PERCODAN are somewhat less than those of morphine and somewhat greater than those of codeine. The usual precautions should be observed as with other opiate analgesics. Although generally well tolerated, PERCODAN may cause nausea, emesis, or constipation in some patients. PERCODAN should be used with caution in patients with known idiosyncrasies to aspirin or phenacetin, and in those with blood dyscrasias. **Also Available:** PERCODAN®-DEMI, each scored pink tablet containing 2.25 mg. oxycodone hydrochloride (Warning: May be habit-forming), 0.19 mg. oxycodone terephthalate (Warning: May be habit-forming), 0.19 mg. homatropine terephthalate, 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine. *U. S. Pats. 2,628,185 and 2,907,768

**Literature on request.**
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# Facts about Michigan Hospital Costs

The Michigan Hospital Association has recently made available the following economic information for 1963 about Michigan short-term acute general hospitals.

The total expense for an average patient stay (7.8 days) was $332.75. (This compares to the national average stay (7.6 days) of $298.05.)

These hospitals spent an average of $42.66 per patient day. (This is $3.75 higher than the national average daily cost of $38.91.)

A breakdown of the patient care dollar is as follows:

| | |
|---|---|
| 4.4% | Housekeeping. |
| 10.6% | Dietary. |
| 13.7% | Pharmacy. |
| 1.1% | Medical Records. |
| 1.9% | Anesthesiology. |
| 6.6% | Laboratory. |
| 5.3% | Radiology. |
| 11.8% | Administration and General Supervision. |
| .5% | Inhalation Therapy. |
| 5.0% | Medical-Surgical Service and inter-resident service. |
| 5.9% | Plant Operation. |
| 2.6% | Laundry and linen service. |
| 32.3% | Nursing service, education, operating room and delivery. |
| 8.3% | Other expenditures such as social service, blood bank, ambulance, outpatient services and depreciation. |

Payroll accounted for about 64% of all expenditures.

Total income from patients and other sources was $260,806,000 while total expenses were $267,996,000 creating a deficit of $7,190,000.

The average daily loss was $1.15 per patient. (In 1962 the average daily loss was $4.71 per patient.)

Private resources paid for 77% of hospital expenses for the aged. (Included in this 77% was 48% paid by Blue Cross, 16% paid by commercial insurance and 13% by private funds.) Government assistance paid for 21% of hospital expense for the aged and the source of payment for the remaining 2% was unknown.

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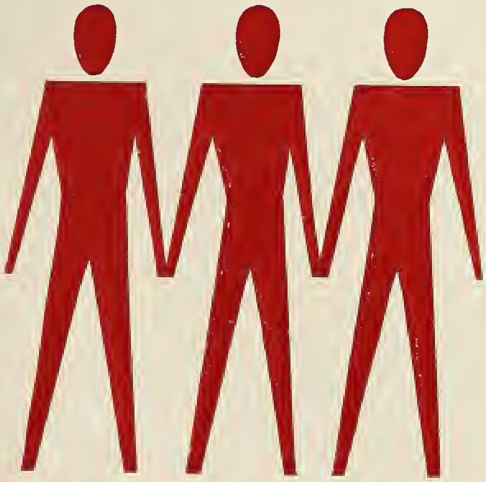
# Appropriate $35 Million For Mental Health Centers

Federal grants-in-aid of $35 million are available for construction of community mental health centers in 1965, the U. S. Department of Health, Education, and Welfare reports.

This sum is the first appropriation under a $150 million three-year program of federal assistance under the terms of the Community Mental Health Centers Construction Act of 1963. Grants will be administered and awarded to eligible sponsors of the centers by the National Institute of Mental Health of the Public Health Services. They will range from one-third to two-thirds of the building cost.

The mental health centers will form the nucleus of the new national mental health program to provide comprehensive treatment of the mentally ill in the patient's home community, HEW reported. To meet the terms of the act, the centers must provide a minimum of the following five essential services: inpatient treatment, outpatient treatment, partial hospitalization, 24-hour emergency service, and consultation and educational services to community agencies.



## SOCIO-ECONOMIC

### AHCP Moves Ahead

A check for over $650,000 was released recently to American Hospital Credit Plan of Michigan, Inc., clearing the way for the Battle Creek company to commence operations on a state-wide basis. The $650,000 represents over half of the authorized stock to be sold in the company.

The company received permission from the Michigan Corporation and Securities Commission to sell 600,000 shares of its authorized stock to Michigan residents.

The Company is offering Michigan residents a credit card system of payment for health expenses.

**Materials for the Medical Socio-Economic Section of MICHIGAN MEDICINE are provided by Richard M. Campau, MSMS Research Director**

*Annual Clinical Conference*

CHICAGO MEDICAL SOCIETY

March 1, 2, 3 and 4, 1965
Palmer House, Chicago

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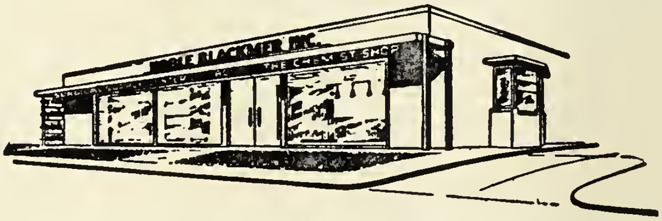

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# Doctor: We Urgently Need Your Opinion!

It is of considerable importance to Michigan Medicine that the following questionnaire be completed, removed from your journal and mailed to MSMS. We urge you to take just a moment for this task, with the assurance that your effort will help us produce a better medical journal for you.

1. My chief professional interest is general practice ( ) or specialty

   ..........................................................................

2. I rate the scientific papers in Michigan Medicine as:

   ( ) Excellent ( ) Fair ( ) Poor

3. I read the pharmaceutical advertising in the journal:

   ( ) Regularly ( ) Sometimes ( ) Rarely

4. I have referred to the local advertising in the journal:

   ( ) Often ( ) Sometimes ( ) Never

5. Please give the name of one local service, firm or institution (professional or commercial) which you have referred to, or purchased from, as a result of seeing its advertising in your journal:

   ..........................................................................

6. Please list the professional journals you read in order of preference. (You may show your opinion of Michigan Medicine by its position on this list.)

   1. ............................ 4. ............................

   2. ............................ 5. ............................

   3. ............................ 6. ............................

7. When examining Michigan Medicine do you more often read papers by authors or from hospitals with which you are personally familiar, than articles from other sources ( ) Yes ( ) No

8. What feature do you like best in your journal? ........................

   ..........................................................................

9. What do you like least? ..................................................

10. What is missing that you would like added? ..........................

# Please Tear Out and Return To:

Michigan State Medical Society
Box 152
East Lansing, Michigan

# Please Answer Questionnaire!

**By B. M. Harris, M.D., Chairman**
**MSMS Publication Committee**

An urgent appeal for your opinions about MICHIGAN MEDICINE is being made in this issue.

On the reverse side of this page, you will find a concise opinionnaire.

May we humbly ask that you fill it in immediately, remove the page from this issue and mail it to the MSMS Headquarters.

The State Medical Journal Advertising Bureau, Chicago, which represents MICHIGAN MEDICINE, has respectfully requested that MSMS cooperate in this nation-wide survey.

The MSMS Publication Committee and The Council are proud of the new MICHIGAN MEDICINE and are confident you will cooperate.

The results of the survey will enable us to further improve your state society journal. Thank you.

* * *

Whenever we organize the content of MICHIGAN MEDICINE, we always begin with the pages of advertising that are sold to help make this publication possible.

As we do this, we often ponder the piercing question, "Does advertising pay?"

MICHIGAN MEDICINE firmly believes it does or we could not accept the advertising in good faith.

One of the best answers to the question was given by Charles G. Mortimer, Chairman of General Foods Corporation, when he made this statement at a stockholders' meeting:

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**1.**

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**2.**

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**3.**

**Mail today to MSMS**

# *"Prove Your Heart" Doctors Are Told*

A leading editor closed his address at the annual American Medical Association Public Relations Institute by saying:

> *"Your genius is conceded. Your techniques are admired. Your researches are held in awe. But these things won't save you from the smothering embrace of the Welfare State. It is your heart that you have to prove."*

These were the observations of J. L. Jones, Editor of the Tulsa Tribune. He has a national reputation as an editorial writer and his editorials have appeared in Reader's Digest and other national magazines. Editor Jones is inclined to call a spade a spade—and he did just that in his speech at the AMA Institute.

Following are some excerpts from his address:

"The feeling that doctors, in general, are not as kindly as their predecessors, that more and more of them are intent on extracting the maximum profit from their patients is perhaps the chief reason for the pressure in favor of expanded socialized medicine.

"While your abilities are now almost universally conceded, your good intentions are coming under increasing question.

"I think that there's a lot that could be done to brighten the image of private medicine in America that simply isn't being done. I say that it is time to accentuate the positive.

"Let America know that the AMA is not only concerned about overcharges, but is prepared to initiate action against habitual abusers even where there are no specific complaints from patients. This is positive.

"Let America know that the AMA is all in favor of health insurance, that it will strongly react to those members who may use it as a device for hiking fees, and that it is searching for new forms of insurance that may provide essential coverages at a cheaper price. This is positive.

"Finally, let the AMA talk more often to the American people—not about what the AMA wants but about what concerns the citizen and his children."

**PUBLIC RELATIONS**

Senior medical students from the two Michigan medical schools, special guests at the MSMS House of Delegates, are shown listening to reports and following along in the delegate's notebook. In the front row are Host Jack Rom, M.D., Detroit, with five WSU students, James Meeks, Martin Zonca, William Munn, Charles Jackson, Henry Taylor. In the back row are Host Harry A. Townsley, M.D., Ann Arbor, and six U-M students, John Markely, John Beernink, Arthur Fleming, Harvey Chapin, Charles Henry and Terry Chamberlain. Also in the second row, at the far right and partially hidden, is James Reese of WSU.

---

## Urges MAA Knowledge

"It is apparent to me that it is mandatory that physicians and their medical assistants become totally aware of the provisions of the Kerr-Mills Act (MAA), so that they can properly answer questions and direct their eligible aged patients to this program.

"In August of 1964, the MSMS sent to each of its members a reference handbook entitled 'Governmental Health Care Assistance Programs in Michigan.' I am sure that in many instances, this piece of literature was overlooked by the busy practicing physician and filed away or lost. I would urge you to seek out this manual and look it over carefully. It is written very concisely and facts about the various governmental programs are easily found. In addition, your medical assistant should become totally aware of the contents of this manual.

"With the physicians fully cognizant of the provision of MAA and the literature in the office available to the patient, then and only then can the full impact of MAA be known."

—Robert F. Powers, M.D.,
On his President's Page
In *Saginaw County Medical Society Bulletin,* Vol. XVI, No. 8

*Best Wishes for 1965*

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# ANCILLARY SECTION

## MICHIGAN MEDICAL EVENTS

**January 22-23**—13th Annual Symposium on Blood, Wayne State University Auditorium, McGregor Memorial Conference Center, Detroit

**February 22-26**—Canadian-American Medical and Dental Ski Association, Boyne Highland, Harbor Beach

**February 27**—Michigan Heart Day, Statler-Hilton Hotel, Detroit

**March 11-12**—MSMS Maternal and Perinatal Welfare Conference, Pick-Durant Hotel, Flint

**March 26-27**—Congress of Michigan Association of the Professions, Pantlind Hotel, Grand Rapids

**April 25**—Michigan State Medical Assistants Society Seminar, Ann Arbor

**May 19**—Wayne State University School of Medicine Clinical Program and Alumni Reunion, Detroit

Miss Phyllis Marquardt, right, Kalamazoo, was installed as the president of the Michigan State Medical Assistants Society at the 15th Annual MSMAS Convention by Mrs. Dorothy Brandis, Lansing, outgoing president.

## Annual Resident's Day In Obstetrics, Gynecology At WSU, March 24

Speakers are announced for the "Seventh Annual Resident's Day in Obstetrics and Gynecology" at Wayne State University, Wednesday, March 24.

The morning session will begin at the Wayne County Medical Society building at 9 a.m. and continue through an evening program until 8:30.

The "visiting faculty" will include: Donald G. McKay, M.D., Chairman, Department of Pathology, Columbia University; Tommy N. Evans, M.D., University of Michigan; C. Paul Hodgkinson, M.D., Chief Obstetrician & Gynecologist, Henry Ford Hospital; William W. Jack, M.D., Chief Obstetrician & Gynecologist, Blodgett Hospital, Grand Rapids; Herman A. Ziel, Jr., M.D., Chief, Maternal Health Section, Michigan Department of Health, Lansing. Members of the Wayne State University School of Medicine faculty will serve on Panels.

This year as a special feature, physicians are invited to send any biopsies of the endometrium, ovary or testis that they may have from an infertile patient to the infertility panel of experts for a free consultation and opinion. This must be done not later than mid-February as the material may be used in the morning panel on infertility. Send in the microscopic slides and a history on the ease to Charles S. Stevenson, M.D., W.S.U. and whether the material is used in the panel or not a written opinion will be returned to the sender.

All physicians are invited to attend, and to bring interns and residents from their hospitals. There is no registration fee.

Advance registration by mail is requested, and forms will be sent out promptly upon receipt of inquiries. Luncheon tickets will cost $1.50 and the dinner ticket will be $5.00.

Address all inquiries to Charles S. Stevenson, M.D., Department of Obstetrics & Gynecology, Wayne State University School of Medicine, 1500 Chrysler Expressway, Detroit 7.

## Kresge Grant Given WSU for Eye Institute

A grant of $1 million toward construction of a new eye institute building has been accepted by the Wayne State University Board of Governors from the Kresge Foundation.

The new building, which will be constructed in connection with Harper Hospital will be called "The Kresge Eye Institute of Wayne State University." It will be coordinated with the major construction program in the University Medical Campus. Planning is under way but no definite date has been set for ground-breaking.

Terms of the grant call for Wayne State to provide equal matching funds.

# Welcome, New Members!

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Detroit, Michigan 48206
**Paul Dragulescu, M.D.**
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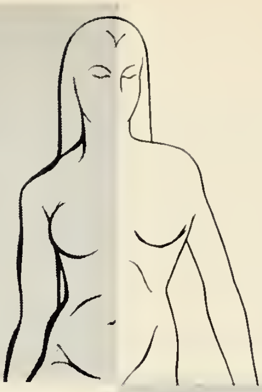

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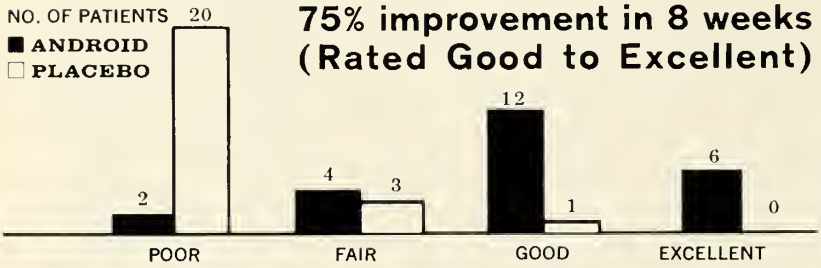

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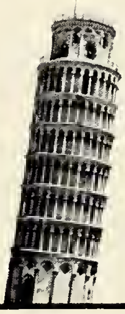
* 1. *Treatment of Impotence with a Methyltestosterone-Thyroid Compound (Android)*, M. H. Dubin, *Western Medicine*, 5:67 Feb. 1964.
2. *Methyltestosterone-Thyroid in Treating Impotence*. A. S. Titeff, *General Practice*, Vol. 25, No. 2, February, 1962, pp. 6-8.
3. *Thyroid-Androgen Relations*, L. Hellman, et al., *The Jrl. of Clin. Endocrinology and Metabolism*, August 1959.
4. Brochure Discussing Thyroid-Androgen Interrelationship.



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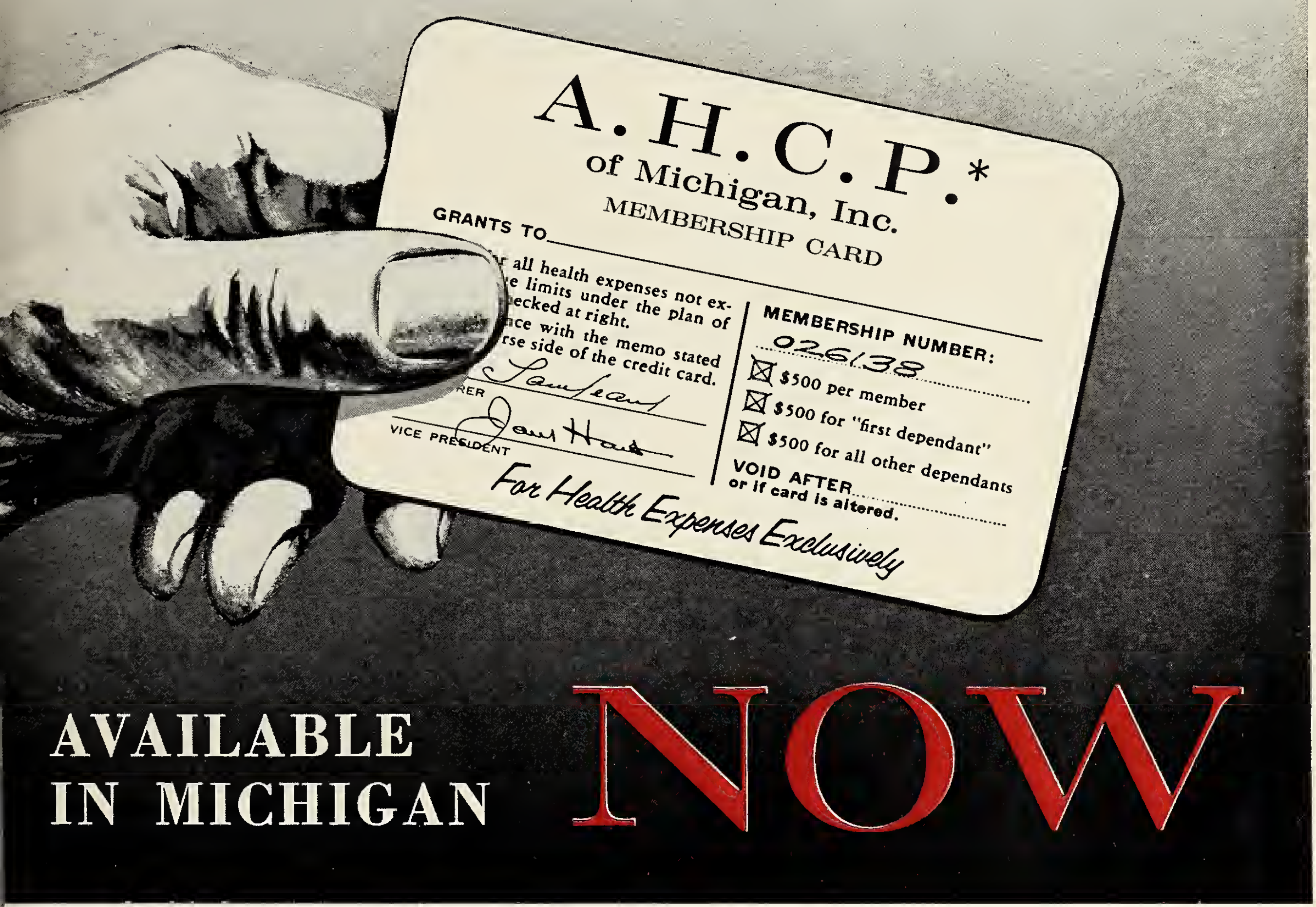

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# AMA Says Owning Pharmacies Ethical

Physician ownership of pharmacies is ethical as long as the patient is not exploited, the American Medical Association told Congress.

Robert B. Throckmorton, AMA General Counsel, testified before the Senate Subcommittee on Antitrust and Monopoly that:

"The ownership of a pharmacy by a physician cannot in itself be equated with exploitation. The confidence and trust that the patient reposes in his doctor—to use his knowledge, his skill, his judgment in prescribing medicines, and his understanding of the patient's financial problems—preclude a blanket charge of physician-pharmacy exploitation.

"It would be a disservice to the public and to the medical profession if from these hearings there issued the unwarranted impression that physicians could not be trusted to own pharmacies or to carry on their professional practices in other more important respects without exploiting their patients. It would be unfortunate . . . if a small incidence of violations and alleged violations came to be accepted as 'proof' of widespread unethical practices."

Mr. Throckmorton pointed out that both the AMA House of Delegates and the AMA Judicial Council had ruled that it is not wrong, per se, for a physician to have a financial interest in a pharmacy. However, he added, the AMA House of Delegates last year adopted flat prohibitions against physician ownership in a drug repackaging company or controlling interest in a pharmaceutical company while engaged in the practice of medicine. He said that there were relatively few cases of such ownership.

Mr. Throckmorton said that less than 2 per cent of the nation's 280,000 physicians have any financial interest in drug repackaging companies.

"Most physicians who acquired financial interests in repackaging firms prior to the AMA statement of policy acted in good faith," he said. "Unless they were a part of the tattered fringe of practitioners who intended to exploit their patients, they had no reason to believe that they were engaging in any unethical act. Many of these physicians who still retain their ownership can, at the most, be censored only for a 'good faith misbehavior.' However, any continued ownership, beyond a reasonable period of time to permit severance without undue hardship, should call for the institution of prompt disciplinary action within the ranks of medicine."

---

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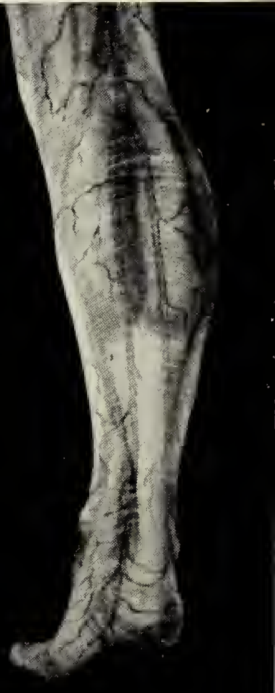

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where ischemia causes muscle distress—pain, spasm, ache, intermittent claudication; also coldness, numbness or ulceration of extremities.

## WSU Medical School Continues Wednesday Series

The Wayne State University School of Medicine continues its series of "Wednesday Afternoon Programs" for all physicians.

Offered at the Wayne County Medical Society Building, the Fundamental Aspects of the Disease Process (FADP) begins at 2:15 with the Student Faculty Assembly (SFA) at 4:00.

Following are the sessions for January and February:

*January 6*—FADP, Dr. Marshall Goldberg, "Obesity"; SFA, Dr. Elliot Luby, Associate Professor of Psychiatry, Lafayette Clinic, Detroit, "Sleep Deprivation."

*January 13*—FADP, Dr. Ernest Muirhead, "The Evolution and Current Concepts of Auto-Immune Disease"; SFA, Dr. Lawrence Weiner, Associate Professer, Department of Microbiology, Wayne State University School of Medicine, "Immunoglobulins."

*January 20*—FADP, Dr. Raymond Read, "Marfan's Syndrome and Lincoln's Illnesses"; SFA, Dr. Richard Mudd, Saginaw, "The Death of Lincoln."

*January 27*—FADP, Dr. Alan Thal, "Pancreatitis"; SFA, Dr. Arthur Guyton, Professor and Chairman, Department of Physiology and Biophysics, University of Mississippi Medical Center, Jackson, Mississippi, "New Concepts on the Genesis of Edema."

*February 3*—FADP, Dr. A. Martin Lerner, "Pneumonia and Its Changing Pattern"; SFA, Dr. Donald S. Miller, Professor of Orthopedics, Chicago Medical School, Chicago, "Peripheral Vascular Problems Associated with Trauma and Orthopedics." (Phi Lambda Kappa Lecture)

*February 10*—FADP, Dr. Alexander Walt, "Carcinoma of the Breast"; SFA, Dr. Donald N. Michael, Institute for Policy Studies, Washington, D. C., "The Social and Ethical Implications of a Programmed Computer Society."

*February 17*—FADP, Dr. G. Jan Beekhuis, "Disturbances of Equilibrium"; SFA, Dr. Fred Guildford, Professor of Otolaryngology, Baylor University, Houston, Texas, "Diagnosis and Therapy of Deafness."

*February 24*— FADP, Dr. Nelson Taylor, "Hypothyroidism"; SFA, Dr. Leslie DeGroot, Massachusetts General Hospital, Boston, Massachusetts, "Hyperthyroidism." (Merck, Sharp and Dohme Lecture)

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# IN MEMORIAM

## PERRY C. BECK, M.D.

Perry C. Beck, M.D., 71, Bronson physician for 44 years, died November 16, 1964, at his residence.

A native of Michigan, Doctor Beck was graduated from Eclectic Medical College, Cincinnati, and spent his entire life in the Bronson area where he was born.

Doctor Bronson was a Life Member of the Michigan State Medical Society.

## JOSEPH BLEIER, M.D.

Joseph Bleier, M.D., 71, Detroit, died November 23, 1964, at Providence Hospital.

A graduate of Wayne State University School of Medince, Doctor Bleier practiced internal medicine in Detroit. He was a member of Temple Beth El and a Life Member of the Michigan State Medical Society.

## FRANK L. DORAN, M.D.

Frank L. Doran, M.D., 68, died December 1, 1964, at his residence in Grand Rapids.

Doctor Doran, a lifelong resident of Grand Rapids, specialized in diseases of the eye, ear, nose and throat. He was a former Chief of Staff of St. Mary's Hospital.

A 1915 graduate of the University of Michigan School of Medicine, he took postgraduate training at Chicago's Shambaugh Clinic.

Doctor Doran was a member of the American Academy of Ophthalmology and Otolaryngology and a Past President of the Kent County Medical Society.

## JOHN F. FAILING, M.D.

John F. Failing, Sr., M.D., 67, Grand Rapids physician for 38 years, died October 30, 1964, at Blodgett Memorial Hospital.

A native of Grand Rapids and former City Physician there, Doctor Failing was a 1926 graduate of Wayne State University School of Medicine. He was Secretary-Treasurer of the West Michigan District of the Michigan Academy of General Practice and once served as President of the state group.

Doctor Failing was a member of the Army Medical Corp stationed in France in World War II. Active in Masonic groups, he was Commander of DeMolay Commandery No. 5, Knights Templar, in 1956, and a member of the Dewitt Clinton Consistory and Saladin Temple of the Shrine.

## ROBERT C. JEREMIAS, M.D.

Robert C. Jeremias, M.D., 47, Detroit obstetrician, died unexpectedly of a heart attack at Pontiac General Hospital, November 7, 1964.

Doctor Jeremias was born in Fremont, Ohio, and was graduated from Wayne State University School of Medicine in 1944. He was a member of the staff of Crittenden General Hospital in Detroit.

He was a member of the American College of Obstetricians and Gynecologists, the International Fertility Association, and the Detroit Surgical Society.

Doctor Jeremias served with the U. S. Navy in World War II.

## GEORGE M. KESL, M.D.

George M. Kesl, M.D., 78, U. S. Public Health doctor from 1913 to 1950, died October 29, 1964, at his home in Port Huron.

Born in St. Louis, Missouri, he was graduated from Washington University Medical College in 1908 and began practice in Port Huron in 1913. He enlisted in the United States Army Medical Corps in World War I and served on the St. Clair County Draft Board in World War II. Doctor Kesl received a citation from former President Dwight D. Eisenhower for his services as medical advisor to the Board. For many years, he was medical officer for the Michigan National Guard Division at Port Huron.

Doctor Kesl was one of the founders and the first Commander of Charles A. Hammond Post No. 8, American Legion, and an Honorary Life Member of that organization. Other honorary life memberships included Port Huron Lodge No. 58, F.&.A.M., and the Port Huron Hospital staff.

## HUGH A. McFADYEN, M.D.

Hugh A. McFadyen, M.D., 82, physician for more than 50 years in Detroit, died November 7, 1964.

Doctor McFadyen was graduated from the University of Western Ontario Faculty of Medicine, London, in 1912 and was a full-time specialist in internal medicine.

His professional memberships included the American Board of Internal Medicine, a Fellow of the American College of Physicians and Surgeons and a Life Member of the Michigan State Medical Society. He was a member of the Scottish Rite and the Shrine.

## RALSTON S. MITCHELL, M.D.

Ralston S. Mitchell, M.D., 65, Detroit physician, died October 28, 1964, at Grace Hospital.

Born in Pomeroy, Ohio, Doctor Mitchell was graduated from Indiana University School of Medicine and Ohio State University School of Pharmacy. He received a master's degree in science from the University of Michigan.

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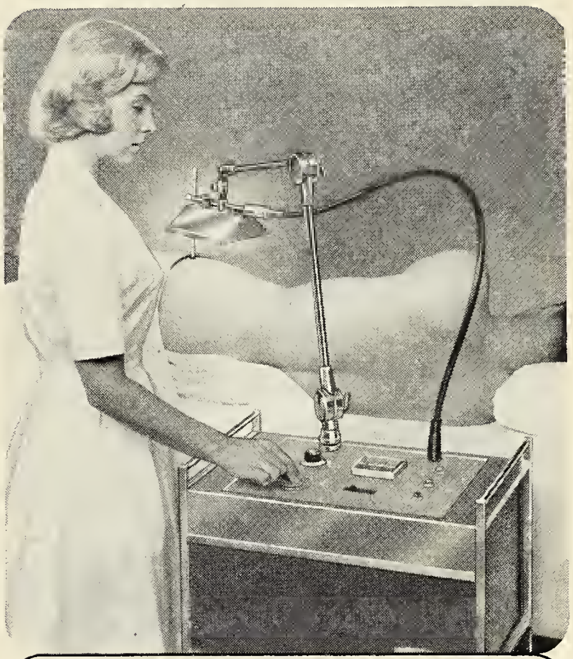

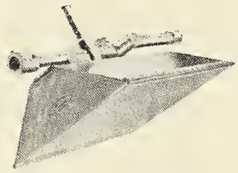

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25 years. He was on the staff at Grace and Burton-Mercy hospitals at the time of his death and formerly was a staff member at Trinity and Parkside hospitals.

He received honor certificates from Homer G. Philips hospital, the Michigan State Board of Registration in Medicine, the Hospital Service of St. Mary's Infirmary and the University of Indiana College of Arts and Sciences.

## DEAN M. RICHMOND, M.D.

Dean M. Richmond, M.D., 68, died November 9, 1964, at St. Joseph where he had served as a general practitioner for over 33 years.

A native of Traverse City, Doctor Richmond was graduated from the University of Michigan School of Medicine in 1927. He interned at Scranton State Hospital, Scranton, Pennsylvania.

Much of Doctor Richmond's career was devoted to industrial medicine and he was elected a fellow of the Industrial Medical Association. Doctor Richmond's hospital affiliations included St. Joseph Hospital, Hancock, in 1928-29, and Mercy Hospital at Benton Harbor.

He served in World War I and was a member of American Legion Post No. 163, Twin City Rotary Club and a member of the choir of St. Paul's Episcopal Church.

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## WALTER Z. RUNDLES, M.D.

Walter Z. Rundles, M.D., 69, Flint specialist in diseases of the eye, ear, nose and throat, died of a heart attack on November 4, 1964, at Hurley Hospital. He was a Past President of the Genesee County Medical Society and was President-Elect of the Flint Academy of Surgery.

A native of Huntertown, Indiana, Doctor Rundles was graduated from Wayne State University School of Medicine in 1925, served his internship at Detroit's Henry Ford Hospital and completed a residency at Receiving Hospital. He took training in his specialty at the Allgemina Krankenhaus in Vienna, Austria; the Massachusetts Eye and Ear Infirmary at Harvard University, and George Washington University School of Medicine in Washington, D. C. He studied plastic surgery at Walter Reed Hospital, Washington.

Doctor Rundles practiced his specialty in Flint for nearly 40 years and served as chief of that department at Hurley, McLaren General and St. Joseph Hospitals.

He was a Navy pharmacist's mate during World War I and in World War II he was a major in the Army Medical Corps where he served in the Pacific theater.

Doctor Rundles spent two months in 1962 on the S.S. *Hope* in Peru.

In 1960, Doctor Rundles was honored by the American Academy of Ophthalmology and Otolaryngology for educational work.

## CLARENCE J. WILLIAMS, M.D.

Clarence J. Williams, M.D., 89, Detroit general practitioner, died July 23, 1964.

Born in Eaton Rapids, he obtained his medical degree from the University of Michigan School of Medicine in 1924 and interned in Wilmington, Delaware. He entered practice in Grosse Pointe in 1926 and was affiliated with Cottage Hospital, where he was Chief of Staff for several years, and Bon Secours Hospital.

Doctor Williams was a member of the American Academy of General Practice, the World Medical Association, and in 1953 served as Chairman of the Section of General Practice of the Michigan State Medical Society.

During World War I, Doctor Williams was a non-commissioned officer in a field hospital unit in France.

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# Readers Write

Dear Doctor McGillicuddy:

Congratulations on your fine article in the October issue of Michigan Medicine. I think that your interest and dedication were well demonstrated in your Message to promote action.

I look forward to seeing you in Lansing and I again thank you for helping to promote good government.

Yours very truly,
Robert E. Waldron, *Chairman,*
Wayne County Republican Committee

Dear Doctor Hiscock:

I want to thank you and The Council of Michigan State Medical Society and the members, in general, of your organization for the invitation which made it possible for me to be your guest at the time of your recent Annual Meeting in Detroit.

It was a pleasure to have the opportunity to meet many of your members and to learn how your state medical society approaches the problems which face all of us.

You are to be congratulated on your fine organization and for the well-ordered manner in which your meeting proceeded. I wish to you continued success in your leadership of organized medicine in Michigan, and I know that your continued success in your leadership of organized medicine in Michigan will have a year of progress ahead of you.

Wilbur E. Flannery, M.D.
*President*
Pennsylvania Medical Society

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Dear Doctor Tupper:

The improved format of the Journal and the new title, MICHIGAN MEDICINE, are all very attractive, and you are doing a fine job as editor.

Very sincerely yours,
Charles S. Stevenson, M.D.
*Professor*
Dept. of Obstetrics & Gynecology
Wayne State University

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John Lambert, M.D., Medical Director, Four Winds Hospital, Katonah, N. Y.

Zigmond Lebensohn, M.D., Chief, Dept. of Psychiatry, Sibley Memorial Hospital, Washington, D. C.

William Sheeley, M.D., Director of Psychiatry & Medical Practice Project of the A.P.A., Washington, D. C.

Philip Solomon, M.D., Chairman, A.P.A. Committee on Medical Practice, Boston, Mass.

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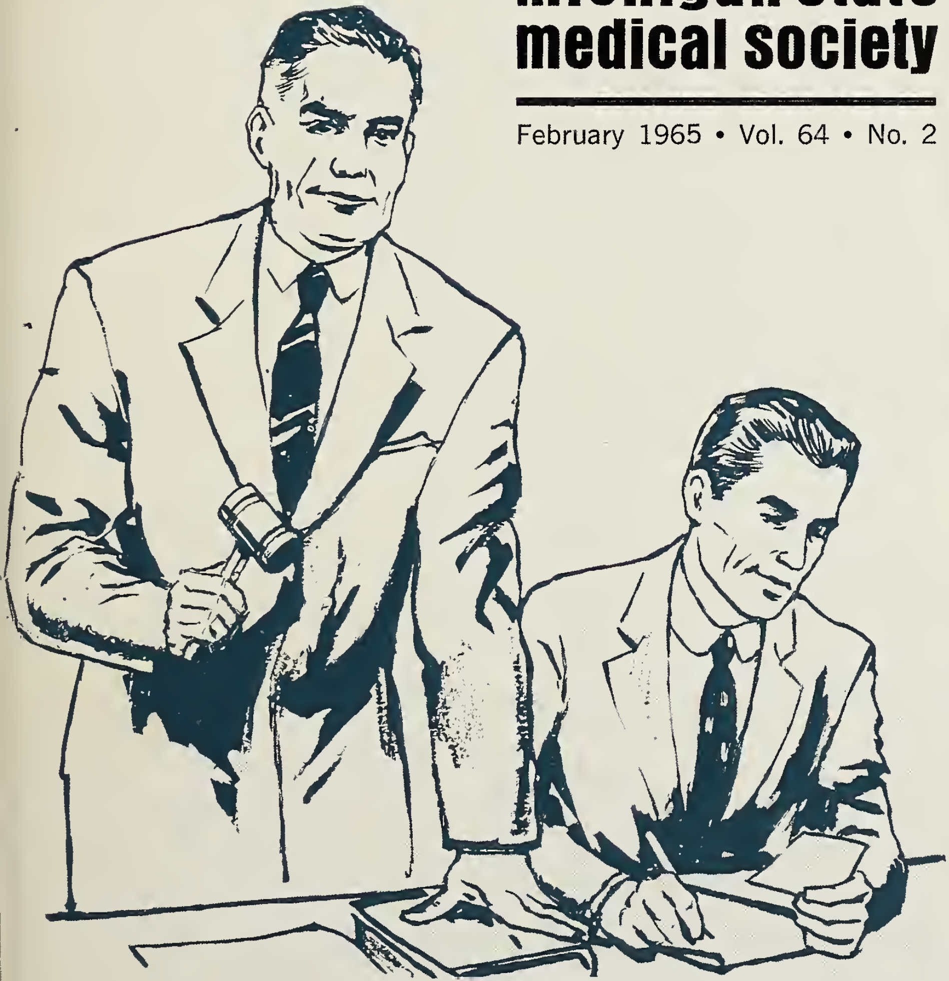

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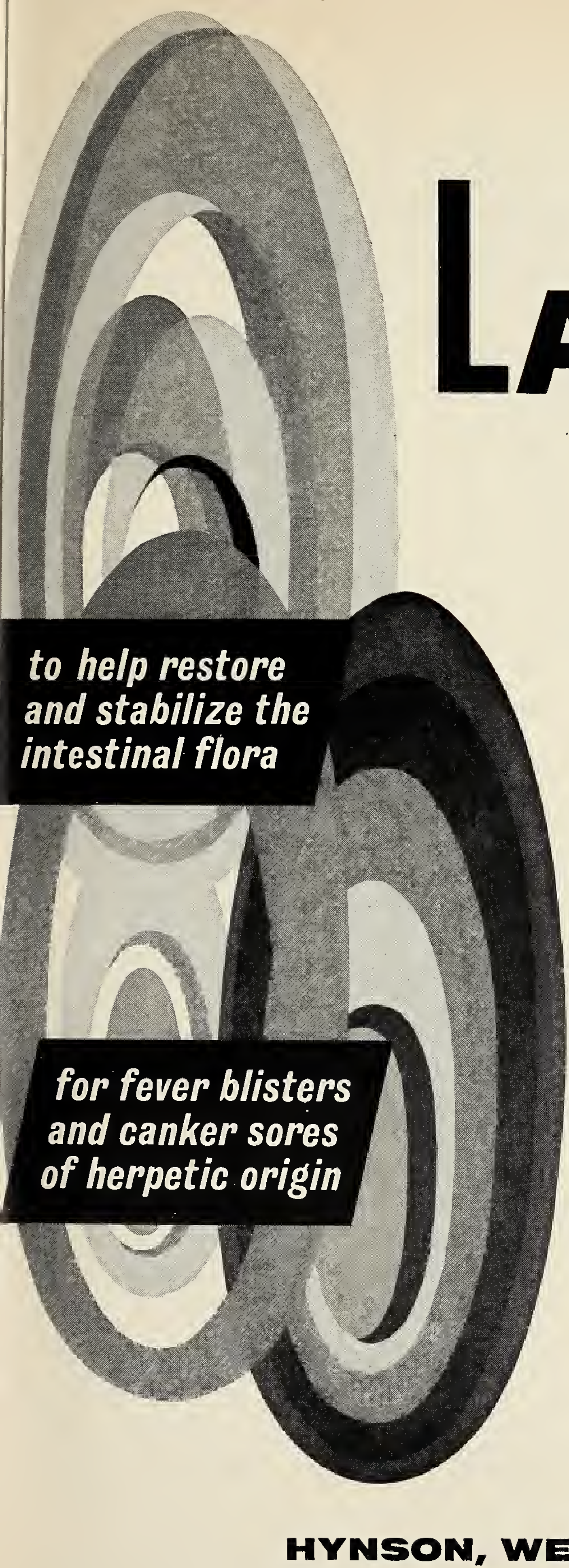
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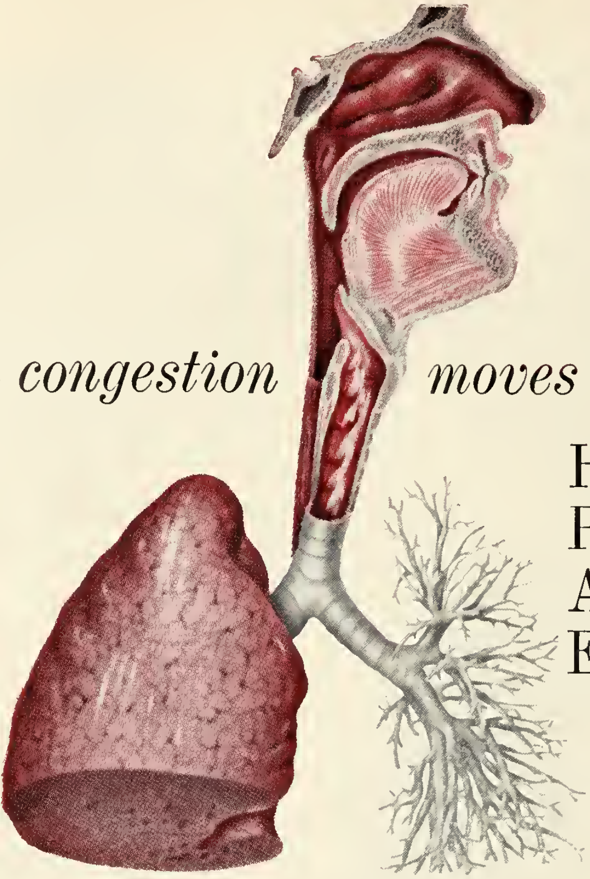

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Published monthly except two extra issues to be published in October and December, by the Michigan State Medical Society as its official journal at 2642 University Avenue, Saint Paul, Minnesota 55114.

Second class postage paid at Saint Paul, Minnesota.

Yearly subscription rate, $9.00; single copies, 80 cents. Additional postage: Canada, $1.00 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year.

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By Michigan State Medical Society

Printed in USA

## *President's Message*

# Counties to Help Observe MSMS Centennial

By OLIVER G. McGILLICUDDY, M.D.
MSMS President

Each year, the new officers of the county medical societies face a rare combination of hard work and great opportunity.

That is especially true during 1965, due to the MSMS Centennial.

One spotlight during the Centennial will be on Detroit. A truly magnificent MSMS Centennial Annual Session September 19-23 is planned. But each physician, each community in the state and surely each county medical society should take this opportunity during the Centennial year to tell the story of medical progress **in their area** of Michigan.

* * *

**We hope each county** society president will appoint a local chairman for the MSMS Centennial observance. Especially, do we want each society to check its own medical history and seek to determine the two or three major medical personalities, medical events or medical contributions made therein during the past hundred years. Information about these can then serve as the focal point upon which each county can base observances of the Centennial.

The officers of MSMS, The Council and the headquarters staff are at the service of the county societies. Information and advice are available to assist the county society leaders (see list on page 135) in their work. MSMS chairmen are also eager to assist their counterpart committees on the local level.

* * *

**We appeal to each** MSMS member to participate more fully in the activities of his county society. The value to our profession of the work of the doctor who participates in the civic, political and religious life of his community is incalculable. But particularly this year each of us has a once-in-a-lifetime opportunity to give our profession a boost through active participation in the observance of the Centennial of the Michigan State Medical Society.

See List of New County Society Officers, Page 135

# in maintenance therapy...
# a working analgesic for the active arthritic

## ARTHRALGEN®

Each tablet contains:

| | |
|---|---|
| Salicylamide | 250 mg. |
| Acetaminophen | 250 mg. |
| Ascorbic acid (Vitamin C) | 25 mg. |

### a working analgesic for the active arthritic

—rapidly relieves early morning stiffness and arthritic pain. It promises a quicker response in most patients because its analgesic ingredients need no metabolic conversion before they act. As a combination of two prominent analgesic drugs, Arthralgen can often establish smoother, more complete pain relief because it synergistically produces more efficient analgesia on lower dosage levels of each.

### two proven pain relievers

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### sodium-free

Arthralgen contains no sodium. Therefore, it is often a safer and more suitable analgesic for use in the long-term treatments of arthritic patients who have other conditions which require sodium restriction.[1]

## ARTHRALGEN®-PR (Arthralgen with prednisone)

Each tablet contains:

| | |
|---|---|
| Salicylamide | 250 mg. |
| Acetaminophen | 250 mg. |
| Ascorbic acid (Vitamin C) | 25 mg. |
| Prednisone | 1 mg. |

To help provide dosage flexibility in patients who require steroids, the basic Arthralgen formula is also available combined with prednisone as Arthralgen-PR. Prednisone is favored as the more advantageous steroid for use in Arthralgen-PR because it shows less tendency toward sodium retention, potassium excretion, and steroid-induced hypertension than that which often accompanies the use of cortisone and ACTH.[2]

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**BRIEF SUMMARY**

Arthralgen and Arthralgen-PR are indicated in the management of rheumatoid arthritis, acute gouty arthritis, rheumatoid spondylitis, osteoarthritis, bursitis, fibrositis, and neuritis. Arthralgen may be used for analgesia in colds, flu, and various myalgias.

DOSAGE: One or two tablets four times a day. After remission of symptoms dosage should be reduced to the minimum maintenance level.

SIDE EFFECTS: Nausea, GI upset, or mild salicylism may rarely occur. Symptoms of hypercorticoidism dictate reduction of dosage of Arthralgen-PR.

PRECAUTION: Reduction in dosage of Arthralgen-PR given over a long period should be gradual, never abrupt.

CONTRAINDICATIONS: Hypersensitivity to any ingredient.

As with any drug containing prednisone, Arthralgen-PR is contraindicated, or should be administered only with care, to patients with peptic ulcer, tuberculosis, nephritis, diabetes mellitus, acute psychoses, Cushing's syndrome (or Cushing's disease), overwhelming spreading (systemic) infection, or predisposition to thrombophlebitis.

Arthralgen-PR is generally contraindicated in patients with uremia and viral infections, including poliomyelitis, vaccinia, ocular herpes simplex, and fungus infections of the eye. It is also contraindicated in patients with chicken pox or susceptible persons exposed to it.

SUPPLY: Arthralgen (white, scored) and Arthralgen-PR (yellow, scored) tablets are available in bottles of 100 and 500.

REF: 1. Boreus & Sandberg, ACTA. PHYSIOL. SCAND., 28:266, 1953. 2. Cohen, et al.: J.A.M.A., 165:225, 1957.

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**will calm your anxious working patient—with little or no drowsiness**

When anxiety interferes with work, your patient needs a drug that will calm without causing undue drowsiness. With Stelazine (trifluoperazine, SK&F), you can promptly control the anxiety without producing the sedation seen with certain other agents. Anxious patients can remain active during therapy.

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Stelazine (trifluoperazine, SK&F) produces a fast therapeutic response—often within 24 to 48 hours. The convenient b.i.d. regimen frees patients from the need for a midday dose.

*Principal side effects,* usually dose-related, may include mild skin reaction, dry mouth, insomnia, fatigue, drowsiness, dizziness, amenorrhea and neuromuscular (extrapyramidal) reactions. Muscular weakness, anorexia, rash, lactation and blurred vision may also be observed. Blood dyscrasias and jaundice have been rare. Use with caution in patients with impaired cardiovascular systems. *Contraindicated* in comatose or greatly depressed states due to CNS depressants and in cases of existing blood dyscrasias, bone marrow depression and pre-existing liver damage.

Before prescribing, see SK&F Product Prescribing Information.

Photograph professionally posed.

1. Stoll, L. J.: The Use of Trifluoperazine ['Stelazine'] in General Practice, M. Press *243*:578 (June 29) 1960.

SK&F **Smith Kline & French Laboratories, Philadelphia**

# good reason for good results in G.U. infections–high active urine levels

# TERR

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No other single broad-spectrum antibiotic has been more widely employed in such a great variety of infections—common or difficult—caused by gram-positive or gram-negative bacteria, spirochetes, rickettsiae, protozoa and large viruses, as well as bacteroids and *Enterobius vermicularis.*

Adding to its versatility is a unique variety of dosage forms. For example, only Terramycin among the broad-spectrum antibiotics is available as a *preconstituted solution for I.M. use.* Always ready for immediate injection, it requires no refrigeration and remains stable for at least two years.

Ahead of its time for 14 years, Terramycin remains a broadly effective and dependable antibiotic with a fine record—confirmed by more than 6,000 published papers. Moreover, the incidence of serious adverse effects has been remarkably low.

[1] Foret, J.: Antibiot. Ann. 1958-1959:253.

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# OXYTETRACYCLINE

Contraindicated: In patients hypersensitive to oxytetracycline.
Warning: Reduce usual dosage and consider antibiotic serum level determinations in patients with impaired renal function. Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth.
Precautions: Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy.
All precautions applicable to intramuscular injection should be carefully observed. Intramuscular solutions should be injected well within the body of a relatively large muscle, such as the upper outer quadrant of the buttock or the lateral thigh; do not inject into the lower or middle thirds of the upper arm. Care should always be taken to avoid injecting into a blood vessel or major nerve. Subcutaneous or fat-layer injection should be avoided.
Adverse Reactions: Nausea, diarrhea, glossitis, stomatitis, proctitis, vaginitis and dermatitis, as well as reactions of an allergic nature, may occur but are rare.
Supply:* Terramycin Capsules: oxytetracycline HCl, 250 mg. and 125 mg. Terramycin Syrup: calcium oxytetracycline, 125 mg. per 5 cc. Terramycin Pediatric Drops: calcium oxytetracycline, 100 mg. per cc. Terramycin (oxytetracycline) Intramuscular Solution: available as ampules containing 100 or 250 mg. oxytetracycline/2 cc., Isoject® syringes containing 100 or 250 mg. oxytetracycline/2 cc. and 10 cc. multiple dose vials containing 50 mg. oxytetracycline/cc.

*All potencies listed are in terms of the standard, oxytetracycline.

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## NEWS BRIEFS

**Lloyd L. Savage, M.D.**, who practiced in Caro since 1931, has retired and moved north of Caseville. He was President of the Tuscola County Medical Society twice and was a long-time MSMS Delegate.

**Joseph A. Preston, M.D.**, Jackson, has been elected to the board of directors of the Gelman Instrument Company at Ann Arbor.

**E. Charles Price, M.D.**, Petoskey, is serving as Vice-Chairman of the Emmett Republican Committee. He was elected at the organizational meeting of the county committee.

**Col. Keith F. Bennett, M.D.**, former commanding officer of the 317th Convalescent Center unit of the U. S. Army Reserves, recently received the Army Commendation Medal, First Oak Leaf Cluster in a Sixth Corps ceremony at Battle Creek.

**Frederick W. Van Duyne, M.D.**, is the new Chairman of the Genesee County Republican Committee. He has been active in Republican party affairs since 1960 when he began his practice in Flint.

**Lawrence R. Banner, M.D.**, and **Frederick C. Ryan, M.D.**, Kalamazoo, recently were honored for 20 years of service to the Old Lake Farm Boys Home and Dewing Hall for Girls now known as Lakeside, a home for teenagers.

Eight Detroit doctors spoke at the annual meeting of the Radiological Society of North America in Chicago. They were **Doctors John N. Wolfe, Kenneth D. McGinnis, Carl L. Zylak, Joseph A. Rinaldo, Jr., Max D. Clark, James E. Garmen, Robert E. Hinson** and **William R. Eyler.**

**Clifford D. Benson, M.D.**, Detroit, has been given a rare honor—he was elected a member of the British Association of Pediatric Surgeons. Dr. Benson, chief of surgical services at Children's Hospital, becomes the 10th surgeon from the United States to be so honored by the international association.

**Steven J. Figiel, M.D.**, Detroit, is a newly elected trustee of the American College of Gastroenterology, chosen at the annual meeting in New York.

*(Continued on Page 82)*

**Hygroton®**
**brand of chlorthalidone**
**the long-acting diuretic**

**Indications**
Many types of edema involving retention of salt and water.
**Contraindications**
Hypersensitivity, and most cases of severe renal or hepatic disease.
**Precautions**
Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
**Side Effects**
Constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, leukopenia, muscle cramps, nausea, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
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**Availability**
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For full details, see the complete prescribing information.

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*(Continued from Page 80)*

The American Cancer Society national award for volunteer service was given recently to **James W. Hubley, M.D.,** Battle Creek, who helped establish in 1949 the cancer registry now said to be the first such cancer control service in the U. S. organized and manned by volunteers. He was chairman for 12 years, and also chairman of the Michigan Cancer Coordinating Committee.

**Dirk C. Bloemendaal, M.D.,** Zeeland, is spending this term on the medical school faculty at Penn State University. He then will return to practice in Zeeland, where he formerly served as mayor for 10 years.

**Benjamin S. Wells, M.D.,** who had served as chief of staff at the VA Hospital at Fort Custer for a year and one-half, has been transferred to the VA Hospital at Murfreesboro, Tenn.

**Richard Proos, M.D.,** who has practiced at Otsego since 1960, recently joined the staff of Western Michigan University to work in the university infirmary.

**Irving Posner, M.D.,** Detroit, has been appointed Chairman of the Health Committee of the Michigan Youth Commission. Eleanor P. Skufis, M.D., Adrian, is the Vice-Chairman.

The Lansing YMCA "Building Your Marriage" series will include a talk about "Sexual Harmony in Marriage" on February 24, by **Mahlon S. Sharp, M.D.,** Lansing.

**Edward F. Draves, M.D.,** Detroit, received the Citizen Sportsman Award at the annual National Football Foundation and Hall of Fame banquet in Detroit recently. He was cited for 28 years of service to Detroit high school athletics. Among other honors held by Doctor Draves are honorary varsity letters by eight high schools he served, and letters of commendation from nine others.

The Bay County unit of the American Red Cross has presented Crusader awards to **W. G. Gamble, Jr., M.D.,** medical chairman of the county organization since 1964; **John N. Asline, M.D.,** medical advisor since 1950; and **Arlyn Moeller, M.D.,** crusade chairman for 1964.

The Muskegon County Medical Society has presented an "Award for Distinguished Service" to **George L. LeFevre, Jr., M.D.,** who retired last February, after 39 years of practice in the Port City.

Recent placements by the M.D. Placement Service of the Michigan Health Council have included the following: **Abraham Geller, M.D.** (Lansing); **Larry Blair, M.D.** (Hastings); **Guido W. Annessa, M.D.,** (Muskegon); **Lucile K. Kuchera, M.D.** (Ann Arbor, University Medical Center); **Norbert O. Anderson, M.D.** (Chrysler Corp.); **Richard J. O'Malley, M.D.** (Ionia); **Lloyd S. Rotz, M.D.** (Grand Haven).

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**G. W. Annessa, M.D.**
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**Orhan Baybura, M.D.**
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**LeRoy W. Bowersox, M.D.**
Detroit Memorial Hospital
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**Louis G. Brennan, M.D.**
Mt. Carmel Hospital
Detroit, Michigan

**Ralph E. Cadger, M.D.**
719 New Center Building
Detroit 2, Michigan
*Anesthesiology*

**Peter A. DelGiudice, M.D.**
Grace Hospital
Detroit 1, Michigan

**Nevit Ergin, M.D.**
Lapeer State Home
Lapeer, Michigan

**Evangelina Esquejo-Capili, M.D.**
32707 Bertram Drive
Garden City, Michigan

**Richard L. Fox, M.D.**
207 Circle Drive
Traverse City, Michigan
*Internal Medicine*

**Joseph R. Grayson, M.D.**
156 Palmer Street
Pontiac, Michigan 48053
*Pediatrics*

**Basil S. Hadjimihaloglu, M.D.**
2429 E. Milwaukee
Detroit, Michigan 48211
*General Practice*

**William A. Harrity, M.D.**
302 Eastland Professional Bldg.
Detroit, Michigan 48236
*Surgery*

**Philip C. Hessburg, M.D.**
Henry Ford Hospital
Detroit, Michigan 48202

**J. Gilberto Higuera, M.D.**
13700 Woodward Avenue
Detroit, Michigan 48203
*Obstetrics-Gynecology*

**Edward Hinko, M.D.**
Dept. of Mental Health
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Lansing, Michigan
*Psychiatry*

**George C. Hopkins, M.D.**
3183 Mack
Detroit, Michigan 48207

**Bernice Izner, M.D.**
18050 Fairway Drive
Detroit, Michigan 48221
*Child Psychiatry*

**J. Peter Johnston, M.D.**
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**Geza Kovacs, M.D.**
861 Gilford Road
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**A. Martin Lerner, M.D.**
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*General Practice*

**Warren E. Wolfe, M.D.**
450 N. Woodward Avenue
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*Psychiatry*

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344 Glendale
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Sleeping better, Mrs. Smith?

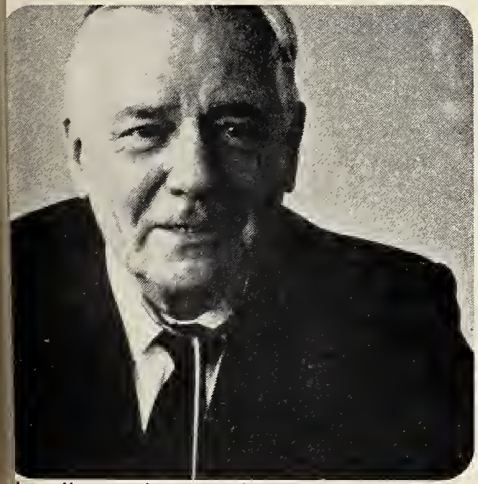
My, yes! I'm not tired out anymore.

Headaches still bother you?

lot at all. I feel wonderful!

Mmm. Normal. Must be taking
your Regroton.

One a day at breakfast.
Sure is easy on me.



ine. I'm cutting you down to
alf a tablet daily.

Thanks for everything, Doctor.
See you on the 3rd.

...excellent response to Regroton,
from 196/120 to 145/90.

*mposition:* Each tablet contains chlorthalidone, mg., and reserpine, 0.25 mg.
*ntraindications:* History of mental depression, persensitivity, and most cases of severe renal hepatic diseases.
*arning:* Discontinue 2 weeks before general esthesia, 1 week before electroshock therapy, d if depression or peptic ulcer occurs.
*ecautions:* Reduce dosage of concomitant antipertensive agents by one-half. Discontinue if e BUN rises or liver dysfunction is aggravated. ectrolyte imbalance and potassium depletion ay occur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.
*Side Effects:* Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
For full details, see the complete prescribing information.

*Availability:* Bottles of 100 and 1000 tablets.
*Average Dosage:* One tablet daily with breakfast.

*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone plus reserpine in moderately severe and severe hypertension: A two year study. Presented at the 7th Inter-American Congress of Cardiology, Montreal, June 14–19, 1964.

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Accidental Death and Dismemberment insurance designed to provide substantial benefits for accidental loss of life, limbs or sight.

## BENEFIT

The amount payable for each loss is shown in the following table.

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|---|---|
| Loss of Life | The Principal Sum |
| Loss of Both Hands or Both Feet | The Principal Sum |
| Loss of Both Eyes | The Principal Sum |
| Loss of One Hand and One Foot | The Principal Sum |
| Loss of One Eye and One Hand or One Foot | The Principal Sum |
| Loss of One Hand or One Foot | One-Half The Principal Sum |
| Loss of One Eye | One-Half The Principal Sum |

## DEPENDENT

The Member may purchase this insurance for his wife if the wife is not eligible as a Member. The amount of Principal Sum on the wife may not exceed 50% of the amount on the Member.

## AMOUNTS OF INSURANCE AVAILABLE

| *Member Only* | *Annual Premium** |
|---|---|
| $100,000 | $72.00 |
| 75,000 | 54.00 |
| 50,000 | 36.00 |
| 25,000 | 18.00 |

### Member and Spouse

| *Member* | *Spouse* | *Annual Premium** |
|---|---|---|
| $100,000 | $50,000 | $108.00 |
| 75,000 | 37,500 | 81.00 |
| 50,000 | 25,000 | 54.00 |
| 25,000 | 12,500 | 27.00 |

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*...nothing, that is, except the*

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SIDE EFFECTS: Blurring of vision, dry mouth, difficult urination or flushing and dryness of the skin may occur at higher dosage levels, rarely at the usual dose.

*This one at Oak Creek, Castle Rock, Arizona

References: 1. Hock, C. W.: Clin. Med. 8:1932, 1961. 2. Marks, L.: Am. J. Gastroenterol. 27:180, 1957. 3. Palmer, W. L., and Kirsner, J. B.: Therapeutics in Internal Medicine, 2nd ed., F. A. Kyser, Ed., Hoeber, New York, 1953, p. 368. 4. Ryan, J. P., Jenkins, H. J. and Robinson, S. M.: J. Pharmaceut. Sciences 53(9):1084, 1964. 5. Vollmer, H.: Arch. Neurol. & Psychiat. 43:1057, 1940. Abst. J.A.M.A. 115:333, 1940. 6. Wharton, G. K., Balfour, D. C., Jr., and Osman, K. I.: Postgrad Med. 21:406, 1957.

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Ilosone produces peak levels of antibacterial activity *two* to *four* times those of other erythromycin preparations. Furthermore, these peak levels are attained earlier with Ilosone and are maintained much longer.

**Side-Effects:** Even though Ilosone is the most active oral form of erythromycin, the incidence of side-effects is low. Infrequent cases of drug idiosyncrasy, manifested by a form of intrahepatic cholestatic jaundice, have been reported. There have been no known fatal or definite residual effects. Gastro-intestinal disturbances not associated with hepatic effects are observed in a small proportion of patients as a result of a local stimulating action of Ilosone on the alimentary tract. Although allergic manifestations are uncommon with the use of erythromycin, there have been occasional reports of urticaria, skin eruptions, and, on rare occasions, anaphylaxis. **Contraindications:** Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction. **Dosage:** *Children under 25 pounds*—5 mg. per pound of body weight every six hours. *Children 25 to 50 pounds*—125 mg. every six hours. *Adults and children over 50 pounds*—250 mg. every six hours. For severe infections, these dosages may be doubled. Ilosone Chewable tablets should be chewed or crushed and swallowed with water.

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**The Michigan Department of Health Laboratories is a laboratory service organization to the physicians and health officers of Michigan. The major activities include a laboratory diagnostic service (including crime detection), the production of biological products, the evaluation of local laboratory service in the area of communicable disease, the training of laboratory personnel and the conduct of research. The development and application of new laboratory procedures is becoming increasingly more complex. Despite the impersonality of present day systems of communication, every effort is being made to provide high grade laboratory service with maximum enthusiasm.**

# Michigan Department of Health Laboratories

BY
G. D. CUMMINGS, M.D.
LANSING

The Michigan Department of Health Laboratories has had five directors in its 76-year history. The present Laboratories (See photo on page 92) are located in Lansing, with branches at Grand Rapids, Houghton and Powers. Within the next year or two, the Houghton and Powers branches will be closed and will be replaced by a new Upper Peninsula branch to be located at Escanaba.

The *physical plant* exclusive of the branches consists of 28 buildings. The *current* staff is composed of 350 individuals trained in a wide variety of laboratory disciplines.

Sixty-two individuals hold the degree of Bachelor of Science; fifteen individuals hold the degree of Master of Science, and twenty-six individuals are Doctors of Medicine, Public Health, Veterinary Medicine, Philosophy or Science. The nine section chiefs and the Director of Laboratories have a combined service record of 229 years.

* * *

*The major activities* of the Laboratories include a laboratory diagnostic service (including crime detection), the production of biologic products, the evaluation of local laboratory service in the area of communicable disease, the training of laboratory personnel from Michigan, other states and other nations, and the prosecution of useful research.

The specific purpose of the Laboratories has been and is to provide service to the citizens of Michigan. This premise has been stated again and again over the years. In 1886, the Michigan State Board of Health memorialized the Board of Regents of the University of Michigan asking for the establishment of a State Laboratory of Hygiene in connection with the University. A bill was introduced into the Legislature of 1887 making an appropriation for this laboratory. The bill passed with an appropriation of $75,000. This was vetoed by the Governor, and the bill was subsequently passed with an appropriation of $35,000.

* * *

*The objects of the* laboratory as stated in this memorial were:

1. The examination of food and drink and other things, which might affect the health of the

**SCIENTIFIC PAPERS**

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Doctor Cummings is Associate Commissioner, Director of Laboratory Services, Michigan Department of Health, Lansing, Michigan.

**Aerial view of Michigan Department of Health Laboratories at Lansing.**

people of the State of Michigan, for the health officers of the State.

2. Investigation or research into the causation of diseases, especially the infectious diseases.
3. The instruction of students in matters pertaining to hygiene.

As late as 1903, Victor C. Vaughn, M.D., the first Director of the State Laboratory of Hygiene (then located at Ann Arbor) stated that: "These objects were stated by the Board of Health in what was believed by the Board to be the order of their importance and as Director of the Laboratory, I constantly hold these in mind."

In 1924, C. C. Young, Dr.P.H., the fourth director of the Bureau of Laboratories (as it was then called) reaffirmed this position in another way by stating that the Bureau "should serve the public through the physicians in a perfectly ethical manner with just as much regard for the physician and his patient as if the physician were doing the work himself."

Thus, over the years the key word for the Laboratories has been Service—service tempered with a high degree of enthusiasm. The definitions of service have remained broad and constant but the content has changed—of necessity—with the times. In the early years, Doctor Vaughn covered the work of his organization with a report devoted to the testing of drinking water, the presence of colon bacillus tyrotoxicons in cheese, and the laboratory diagnosis of diphtheria, hydrophobia and hog cholera.

In the twenties, Dr. Young was concerning himself with the laboratory diagnosis of diphtheria, streptococcal infections, syphilis, gonorrhea, tuberculosis and the enteric infections and with the analysis of milk and water specimens. He had already begun the production of biologic products designed to reduce the incidence of such diseases as diphtheria and smallpox and had initiated a research program designed to improve the laboratory diagnosis of syphilis.

Last year, the Laboratories performed 1,456,568 examinations covering a tremendous variety of diseases and produced 7,400,386 doses of biologic products for the diagnosis, prevention and treatment of a number of communicable diseases.

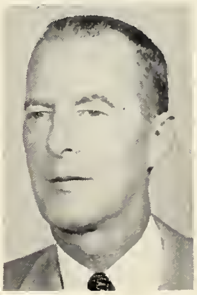
* * *

*Our present interests* and services are more diversified than ever. We now concern ourselves with the so-called old line "routine" services and in addition, our energies are devoted to considerations of the quality of local laboratory service, the training of laboratory personnel, to research, and even to the apprehension of criminals by the laboratory route. We operate a blood fractionation plant which provides free gamma globulin, albumin, fibrinogen, and antihemophiliac globulin to the physicians of Michigan. We maintain important research programs in the fields of cancer, blood fractionation and pertussis—and at this moment we are conducting a study to determine the true incidence of phenylketonuric infants in Michigan. We must also concern ourselves with the presence of detergents in drinking water—in this, the Water Wonderland of the Nation.

All of which reminds me of the time-worn phrase, "A simple laboratory test." There is no such thing as a simple laboratory test. The testing of laboratory specimens has become infinitely more complex. For example:

In the good old days the staphylococcus was an organism of low standing in the social order of bacteria. Today, by virtue of its resistance to antibiotics, the staphylococcus has achieved new stature, and as a result, we must test staphylococci with 22 different bacteriophages in order to produce useful laboratory data.

In the beginning, the typhoid bacillus was reported as *B. typhosus*, then *Eberthella typhi*, then *Salmonella typhi* or *S. typhi*. Today we are required to identify 700 different strains of Salmonella. Some years ago we began to report the typhoid bacillus as S. *typhi* and this caused some



The Author

G. D. CUMMINGS, M.D.

embarrassment among our medical brethren. I remember one health officer who had not had time to do his Salmonella homework. An enterprising reporter asked him what disease was caused by *S. typhi.* The health officer, in a moment of stress, stated that *S. typhi* was the cause of a "rare Oriental disease."

A good many of us were taught that the colon bacillus was an unimportant resident of the gastrointestinal tract and that we could forget it provided we were not urologists. Today, we have both pathogenic and non-pathogenic colon bacilli. There are at least 10 proven pathogenic types and they are identified by such simple terms as: *E. coli* $0111B_4$, $055B_5$, and $0127B_8$.

With the decline in the tuberculosis rate, it was reasonable to expect an equivalent decline in the volume of laboratory work. This has not come about for we have discovered that certain acid-fast bacilli commonly classified as "atypical" or "anonymous" or "unclassified" are important in pulmonary disease. So now, you are receiving reports of the unclassified acid-fast bacilli with the following simple classification system:

Group I—Photochromogens (yellow bacillus)
Group II—Scotochromogens (orange bacillus)
Group III—Non-photochromogens (Battey bacillus)
Group IV—Rapid growers.

One disease which laboratorians were sure would remain static from a laboratory standpoint was rabies. We were convinced that the immunization and control of the dog population would relegate rabies to a relatively unimportant role. Not so. Today, in this State, we are concerned with the detection of rabies in skunks and bats. Indeed, in Michigan the skunk leads the rabies animal parade.

* * *

*You will be* interested to know that we must examine the brains of dogs, cats, cows, horses, pigs, mice, sheep, rats, skunks, guinea pigs, racoons, bats, hamsters, foxes—and even coyotes. In the beginning, we examined brain smears and then we added the mouse inoculation test. Presently, we are also utilizing the fluorescent antibody technique for those specimens which, in our experience, we do not expect to find positive.

Finally, let us consider the viruses. In 1940, Doctor Young made this prophetic statement, "On the horizon are the diseases of the virus group." In the forties, it was not unusual to classify a disease of unknown etiology as a virus disease when no pathogenic bacteria could be isolated. In those days, we had a sufficient number of diseases but not enough viruses to go around. Today, the situation has to some extent reversed itself for we now have more viruses than we have diseases. To name a few viruses: consider that there are 28 definite ECHO viruses, 24 definite adenoviruses, 24 Coxsackie A viruses and 6 Coxsackie B viruses. Lennette in 1962 studied a group of clinically diagnosed cases of aseptic meningitis from which he isolated 23 different viruses.

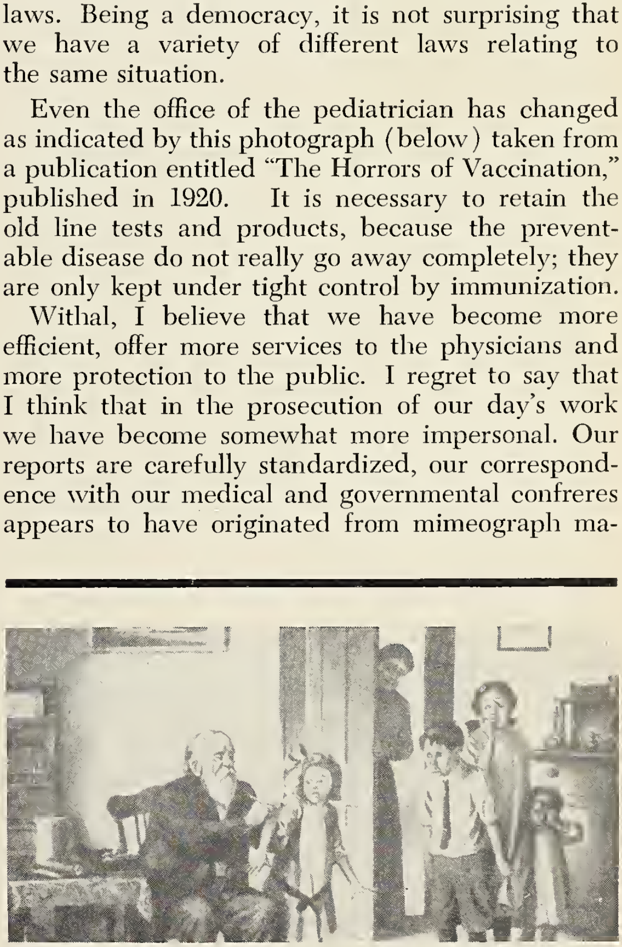
And this is only the beginning. Virus laboratory work is laborious and time consuming and it does not lend itself to line production methods. We cannot run through 1,000 specimens per day as we do in the serum diagnosis of syphilis. There is a need on the part of the physician to do some epidemiologic surveillance work in the virus disease field and to select patients and specimens for virus diagnosis with extreme care. In epidemic situations, a few carefully selected specimens will very often yield an accurate picture of the local situation.

* * *

*In the net,* we may say that laboratory work along with the practice of pediatrics—and I might add the due process of government—has become much more complex. As pediatricians, you have had little opportunity to run afoul of the premarital laws relating to venereal disease and the dilemma created for both physicians and patients by these laws. Being a democracy, it is not surprising that we have a variety of different laws relating to the same situation.

Even the office of the pediatrician has changed as indicated by this photograph (below) taken from a publication entitled "The Horrors of Vaccination," published in 1920. It is necessary to retain the old line tests and products, because the preventable disease do not really go away completely; they are only kept under tight control by immunization.

Withal, I believe that we have become more efficient, offer more services to the physicians and more protection to the public. I regret to say that I think that in the prosecution of our day's work we have become somewhat more impersonal. Our reports are carefully standardized, our correspondence with our medical and governmental confreres appears to have originated from mimeograph ma-



**"The Medicine Man performs his Savage Rites"**
**—From Harper's Weekly, Feb. 24, 1912**

chines and certainly our method of communication lacks the warmth, the humor, and the spark of the old days.

* * *

*Consider the* following examples of communication techniques from the past. This comment from Doctor Vaughn in 1903:

"I wish that you could see some of the samples that come to the laboratory for examination. Some of them are taken in such a way as to endanger the life of everybody touching them from the time they are taken out of the child's throat until they reach the laboratory.

"I have received great pieces of diphtheritic membrane rolled up in a cloth. I have received samples crowded down into a bottle, and a part of it on the outside of the bottle. Whenever I receive such a sample in such a condition I throw it into the fire as quickly as I can.

"We cannot examine samples received in that way, and besides, it is dangerous to send samples in that way. I wrote to a health officer the other day scolding him for sending me such a sample. He replied, 'I would not send you a piece of diphtheritic membrane without sterilizing it. I thoroughly sterilized the membrane before sending it.' If he knew that all of our work depended upon the germ being alive when it got here he would have realized the predicament he was placing us in."

This feud between Dr. M. C. Holm, the State Bacteriologist from 1908 to 1915 and a physician in Western Michigan regarding the proper submission of a laboratory specimen. Doctor Holm ended an exchange of fiery letters with this closing paragraph:

"To show that I harbor no ill feelings toward you as a result of this altercation, I am forwarding you a five cent cigar, postage paid. This cigar is used by that type of individual, who by virtue of his lack of weight, floats upward. As far as I am concerned, the incident is closed."

Or this correspondence in 1923 between Doctor Young and a physician whom I shall call Doctor X about split specimens: Letter from Doctor X to Doctor Young:

"In regard to the case of Mrs. Gumper. This is not a case of typhoid fever. It is a case of diabetes mellitus. The patient was in the local hospital, and her gall bladder was drained by the Meltzer-Lyon method. Four specimens of bile were obtained and all four were sent to the State Laboratory for culture. Two bottles under the name of Mrs. Gumper and two under the name of Mrs. Robinson. Both reports came back positive for typhoid."

Letter from Doctor Young to Doctor X:

"We have your letter of explanation of June 19th about the bile taken from Mrs. Gumper which was divided and sent in under both the name of Mrs. Gumper and Mrs. Robinson. I am wondering just how long it is going to take for you people to find out we do our work properly and that the same bacteriological judgement would be given one sample as another. The accuracy and dependability of our results to physicians can be questioned insofar as the accuracy of the methods in vogue are open to question."

"I have stood ready for five years to go the limit for every physician in Michigan who would cooperate with me and will continue to do so. *But I do not like split specimens.* They make me mad whenever we get them and if you want to check our laboratory procedures, send the split sample to some other laboratory."

* * *

*In my own experience* I can offer two examples of humor in communications: The first example relates to some correspondence with the Civil Service Commission relating to the 100 per cent 180-day probationary rating which was submitted on Doctor Cope, for many years our Clinical Pathologist: Letter to the Personnel Officer of the Michigan Department of Health:

"We are writing in reference to the 180-day probationary period service rating submitted by your agency for Dr. Henry E. Cope, Clinical Pathologist VI. The rating given Doctor Cope is 100 per cent. We do not question the excellence of Doctor Cope's performance on the job. Neither do we question the great amount of knowledge and skill which Doctor Cope possesses. However, as a mere mortal, I question and envy Doctor Cope in having attained absolute perfection. The rater, being a mere mortal, may wish to reconsider this rating in the light of both natural and supernatural attainment. We are therefore returning it for your consideration."

My answer to the Civil Service Commission:

"Mr. Murray, Personnel Officer for the Michigan Department of Health, has referred your letter to me relating to the 180-day Probationary Period Service Rating on Dr. Henry E. Cope. I am highly gratified to know that you do not have the temerity to question the excellence of Doctor Cope's job performance, knowledge or skills. This, I am sure, would be flying in the face of fate—even for an acknowledged expert in personnel procedures.

"I would agree with you that a mere mortal would find himself in a rather untenable position in taking it upon himself to question absolute perfection. This is perhaps due to the fact that being a mere mortal has decided limitations. However, it was my belief that the rater and the Civil Service Commission were somewhat in agreement regarding Doctor Cope's abilities in view of the fact that the Commission recently informed Doctor Cope that he had received a final rating of 100 per cent (position number 1) on the examination for the eligible list for Clinical Pathologist VI. For your information these data appear on Civil Service Commission Form CS-103P entitled 'Notice of Promotional Examination Results.' Needless to say, Doctor Cope cherishes this document and except for periods when he shows it to his closest friends, he keeps it in the Laboratories' safe. This is probably because he realizes that the mere mortals in the Civil Service Commission may also wish to reconsider his rating in the light of both natural and supernatural attainment. On the philosophical side, I must admit that we both must be considered as mere mortals in this transaction although there are times when I think either of us could attain an even more elevated status. At this time I am not prepared to say which of us would get there first. Philosophically too, it would seem to me that the Commission on Form CS-103P had delved somewhat into the realm of immortality itself by conferring a final rating of 100 per cent on Doctor Cope. I find no evidence in the regulations of the Commission or in the Constitutional Amendment creating the Commission establishing the right to confer immortality on any individual in the State Service. You will be interested to know that I expended considerable effort trying to decide whether Doctor Cope should be given 99 per cent or 100 per cent. I finally admitted to myself that in view of the fact that it took Doctor Cope approximately 10 years, 3 months, and 10 days to be placed on probation as a Clinical Pathologist VI he richly deserved the additional 1 per cent.

"You will also be interested to know that certain other individuals on the Laboratories' Staff have been rated at the 100 per cent level. This group unfortunately does not include the Director since he is not in a position to prepare his own rating.

"I have tried to exercise my best judgement in this matter and having done so, find that I still concur with my original decision. I am, therefore, returning Doctor Cope's Probationary Service Rating to you with my best regards."

The second example relates to a letter to my secretary from a high Federal Government official following his receipt of a letter which I had forwarded him marked "Personal and Confidential." Here is his answer:

"Today I received a communication from your employer prepared by you, marked, I am sure, at your employer's direction: 'Personal and Confidential.' Now, this phrase has a specific and universal connotation and acceptance—except around here. Since the phrase includes the term 'Confidential' which is one of the official categories of security classification, and since the transmission of 'Confidential' material in an envelope openly so marked would constitute a security violation, mail with this designation is immediately dispatched from the mail room by rapid—relatively—messenger to the Security Office for opening and inspection. Thus, it follows, that the one positive way of assuring violation of the 'personal and confidential' nature of a communication is to so mark it.

"Neither delay, censure, nor other harm have resulted in this case. Rather, my concern is related to that possible future instance, when, again on behalf of your employer, you might be transmitting a reminder of long over-due payments on a wager, or some equally intimate matter.

"Please—mark it: 'Personal,' or 'To Be Opened By Addressee Only,' or even 'Do Not Open 'Til Xmas' might work, but *not* 'Confidential.' My regards to your employer."

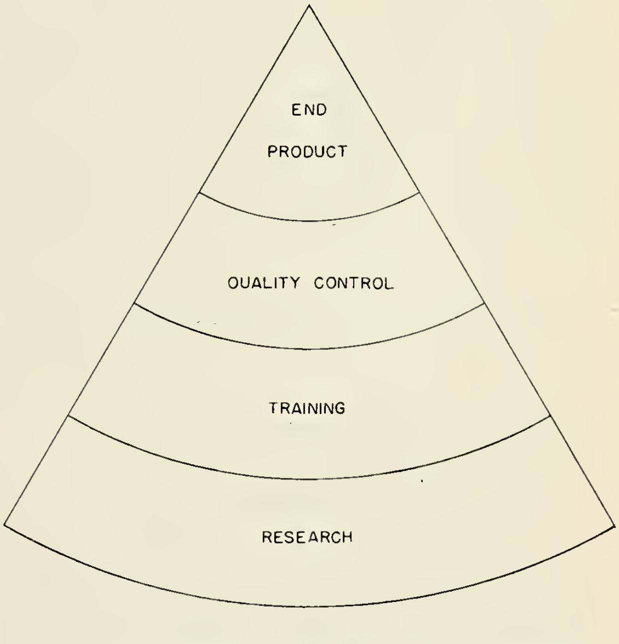
* * *

*A word now* about the future. The future programs of the Michigan Department of Health Laboratories will continue to be service oriented—defining service in its broadest sense. If we are to continue to provide good laboratory service to the people and to the physicians of Michigan, we will have to exert greater effort in the areas of quality control, training and research—being always mindful of the continuing need for the provision of useful end products at reasonable costs. These service areas must be properly integrated and with some order of priority.

SERVICE PATTERN

DIVISION OF LABORATORIES

MICHIGAN DEPARTMENT OF HEALTH



The relationships of these services to one another are illustrated above. The end product is based upon research, and quality control and training are necessary adjuncts to the sound application of the end product.

The need for quality control in laboratory work is attested to by the fact that there are presently 357 registered local laboratories in Michigan manned by many laboratorians performing hundreds of different laboratory tests annually. Our present experience in the area of quality control is limited only to those laboratory examinations which are performed in relation to the control of the communicable diseases. If our experience in this area is valid, then quality control should encompass a myriad of other laboratory tests.

The need for the provision of a wide variety of laboratory training courses for local laboratorians is clearly evident. The speed with which research evolves new tools does not equate with the rate of application of these tools. A physician may read of a new laboratory test in one of his journals and then have to wait months or even years before the test becomes freely available to him for use in his practice.

The local laboratorian must be given the opportunity to learn new techniques rapidly and accurately in short carefully planned training courses, for the average laboratorian is already a very busy person. Soundly planned courses should give him the chance to learn such procedures as the fluorescent antibody technique or the complement fixation test for certain of the viruses. We also consider sound training courses to represent another route to quality control.

Research is a continuous and productive process. There are few procedures or products which have remained unchanged over the years. Consider the laboratory tests for syphilis, for example. As a young bacteriologist in our laboratories, I watched Doctor Kahn and his colleagues develop and apply the Kahn precipitation test—a test which has rendered distinguished service in its time.

But the Kahn test has come and gone and in its place we now have such tests as the VDRL test, the TPCF test, the RPCF test and the TPI test. Even these tests are not 100 per cent accurate and the search for the perfect test will continue. I also have had the pleasure of watching my colleagues develop the first production process for the recovery of normal serum albumin from human placental blood. I discussed the chances for the success of this project with an eminent laboratorian skilled in blood fractionation techniques and he classified our proposed project as an act of lunacy.

In rebuttal to this statement, I referred to the late Boss Kettering of the General Motors Corporation who once stated that he always gave a tough developmental job to young men because they were not old enough to know that the job could not be done. Our young chemists came through with flying colors.

* * *

*Be assured* that we shall try to keep abreast of the times, that we shall endeavor to plan well for the future and that we shall do our job with diligence and enthusiasm. I have mentioned enthusiasm several times in this presentation, for without enthusiasm laboratory work would indeed be a dull business.

I would like to close this presentation by referring to another enthusiast who some years ago wrote a report "Concerning the Cause of Typhoid Fever." He concluded his report with this paragraph:

"The foregoing may serve to briefly indicate to those not already familiar with the subject some of the views now held by physicians in different parts of the world, and may, perhaps, lead to more definite observations, and reports to this Board, of facts bearing on these important questions—facts which can as well be observed in Michigan as in foreign countries, if only the necessary enthusiasm shall be aroused in those properly trained for observation in such studies."

The man was Henry B. Baker, M.D., the first Secretary of the State Board of Health of the State of Michigan. The time, September 30, 1876.

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# Among the Great Printing Changes

Considerable curiosity and interest has been expressed by MSMS members in the 3-D advertisements presented each month in Michigan Medicine.

This process was developed by *Look Magazine* in conjunction with Eastman Chemical Products, Inc. and the Harris Intertype Corporation.

The process itself is extremely complex and is explained by Marvin Whatmore, President of Cowles Magazines and Broadcasting, as follows: "In this process, a screen is put in front of the film when a photo is taken. The screen divides the picture into hundreds of tiny, vertical, parallel strips. The photo is developed, and press plates are made in the conventional manner. In the printing process, a viewing screen is applied by coating the printed surface. This screen focuses on the tiny strips in the picture and provides the viewer with the illusion of depth."

A recent story in *Saturday Review* about the 3-D process expressed the opinion that "the process represents no more than the fourth major breakthrough in printing technology since the fifteenth century." The first 3-D print by this process appeared a year ago, in the February issue of *Look Magazine.*

Couples trying unsuccessfully for a pregnancy for a period of one or more years should be treated actively for infertility. No reassurance should be given until a thorough study is made.

No survey is complete until culdoscopy or laparotomy has disclosed normal female pelvic organs. Overemphasis has been placed on underdevelopment of the secretory endometrium as a cause of infertility.

# The Investigation of Infertility

BY ROBERT W. NOYES, M.D.
NASHVILLE, TENNESSEE

It is surprising how few women offer infertility as a chief complaint. This may be due in part to embarrassment, but is also due to lack of knowledge on the part of the patient that infertility can be diagnosed and treated in the same way as a disease. For this reason, the most important role of the physician is to evoke the symptom of infertility, and then to inform the patient and her husband so they can reach objective decisions with regard to their reproductive problems.

Infertile couples should be told that the birth of normal children is the result of an exceedingly complex interaction between husband, wife, and divine providence, and that no physician really knows enough to "give them a pregnancy." Rather, the role of the physician is to discover existing causes for infertility and to treat them if indicated.

The infertile couple should be impressed with the fact that the success of the investigation does not depend on pregnancy, but rather on discovery of the cause for infertility. If the physician carefully discusses his findngs with the couple they will feel benefited whether the individual tests are positive or negative. In return for the discomfort and expense of approximately six months of medical investigation, the couple should be promised only knowledge related to fertility, the advantages of having had a thorough check-up, and a definitive recommendation for adoption should this later become desirable— but never that a pregnancy is likely.

* * *

A COMMON FAULT of many physicians is to examine a woman superficially and then to reassure her, implying that she will conceive soon—even though her infertility has lasted many months. Whitelaw has shown that conception occurs within one month in 57 per cent, within six months in 79 per cent, and within one year in 87 per cent of fertile couples. McLeod has found that when couples were infertile five or more years and the wife was more than 30 years old, only 7.5 per cent achieved a pregnancy, whereas when the infertility had lasted one to three years and the wife was younger than age 30, 40 per cent finally achieved a pregnancy. These data clearly suggest that an active infertility investigation should be instituted in any couple not conceiving ½ to one year after trying, particularly if the wife is approaching 30 years of age.

An outline of a standard infertility study has been published by the American Society for the Study of Sterility and is available at very low cost from the secretary (944 South 18th Street, Birmingham, Alabama).

* * *

FOLLOWING A COMPLETE history and physical examination of the wife and husband, it is essential that the husband's fertility be evaluated by an analysis of semen or a post coital examination of the wife's cervical mucus for motile sperm. The patency of the tubes should be checked by gas insufflation, hysterosalpingogram and, if necessary, culdoscopy with the injection of methylene blue dye through the oviducts under direct vision. If the semen was found to be normal, yet the cervical mucus was devoid of motile spermatozoa following intercourse, the administration of small doses of estrogen and perhaps antibiotics should be given, and husband insemination may be attempted. *In Vitro* tests of the husband's spermatozoa against both cervical mucus and serum may disclose immunologic incompatibility. Much remains to be learned in this interesting area.

The occurrence of ovulation is determined by the recording of basal body temperatures. An endomentrial biopsy, taken several days after the mid-cycle rise in temperature, will disclose endometrium with a secretory histologic pattern. A less desirable time to take the endometrial biopsy is at the beginning of menstrual flow. Examination of such biopsies has caused pathologists considerable difficulty, not so much in the confirmation of the fact that ovulation has occurred, but rather in the quanti-

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tative evaluation of the ripeness of endometrial development.

* * *

IT IS IMPOSSIBLE in a brief review to expand on all of the steps in the diagnostic survey of infertile couples. However, one area that causes considerable difficulty is the "hypoluteal state." This term has many synonyms, all of which suggest that in an otherwise normal woman the corpus luteum may fail or the endometrium may fail to respond to progesterone, resulting in an inadequately prepared bed for the fertilized ovum to implant. Much has been written about this condition, and prevalence from 7 to as high as 66 per cent in infertile couples has been reported. One thousand seven endometrial biopsies were studied by Noyes and Haman, and it was found that although a large number of endometrial histologic patterns appeared to be underdeveloped, on careful study several kinds of artifact were found that contributed to this misimpression. In fact, no more patients had underdeveloped than overdeveloped endometria.

The diagnostic accuracy of endometrial biopsies can be improved by observing the following eight practical points:

(1) Obtain biopsies during the secretory phase of a cycle in which basal body temperatures have been well established. This will allow a comparison between histologic maturation and the point at which the temperature shifts (the onset of progesterone effect) and also with the onset of menses succeeding the biopsy (withdrawal of progesterone effect).

(2) The best time to take the biopsy is at the middle of the secretory phase. Menstrual endometrium cannot be quantitatively evaluated. Late secretory endometrium will spuriously appear to be underdeveloped and early secretory endometrium may spuriously appear to be overdeveloped because there is a tendency for measurements taken at the extreme ends of a scale to deviate towards the mean. By taking readings near the middle of the scale this artifact is obviated. The middle of the secretory phase is also the time the ovum is implanting, and is therefore a logical time for observations to be made. Clinical experience has suggested that there is no more hazard to pregnancy when biopsies are taken at the middle than at the end of the secretory phase.

(3) Endometrium should be obtained from the surface of the fundal portion of the endometrium, which is the only part of the endometrium that is maximally responsive to progesterone.

(4) Endometrium should be fixed in Bouin's fluid and sections should be made all the way through the paraffin block.

(5) The physician should look at his own slides and should consult with a qualified and interested pathologist.

(6) Only the best developed areas of fundal surface endometrium should be examined. The deeper and lower areas are not exposed to the ovum and the degree of development of these areas is not pertinent to fertility.

(7) The histologic development of endometrium should be graded by some objective system such as the endometrial dating system of Rock and Bartlett or its equivalent. In the dating system eight specific criteria are compared with each other and a single date is recorded as a diagnosis. This permits a numerical comparison between the date of shift of temperature and onset of menses with the date on which the biopsy was obtained.

(8) The accuracy of the endometrial dating method is plus or minus two days, so a biopsy should not be called "underdeveloped" unless the histologic date is more than two days below the date on which the biopsy was obtained.

Once underdevelopment of the endometrium has been established, can it be successfully treated by the administration of exogenous hormones? An attempt was made to do this by administering estrogen, or progesterone, or chorionic gonadotrophin between the time of ovulation and implantation, and evaluating the change in endometrial development in comparison with that of a control cycle. In 12 patients given progesterone alone there was no change in the endometrial development, whereas estrogen inhibited endometrial development in 12 patients. Chorionic gonadotrophin advanced endometrial development to a very small extent, but the combinations of estrogen and progesterone, and estrogen, progesterone, and chorionic gonadotrophin did not improve the result.

* * *

BECAUSE EXTENSIVE animal experimentation suggested that moderate underdevelopment of the endometrium is actually less detrimental to ovular implantation and survival than slight overdevelopment, there appears to be little or no indication for hormone therapy attempting to advance endometrial development in infertile women. Small doses of estrogen given between the time of ovulation and of implantation are perhaps more logical.

In conclusion, it may be pointed out that between 10 and 20 per cent of married women reach the menopause with no children or fewer children than desired. Infertility is more commonly due to several different factors (Siegler) than a single factor. The diagnostic survey discloses definite causes of infertility in about 40 per cent of thoroughly studied couples, and another 40 per cent will became pregnant during or shortly after the conclusion of the study. Only about 20 per cent will remain infertile without obvious cause and have to be considered as "failures" from both the physician's and the patient's viewpoint.

# TRAUMATIC CHYLOTHORAX

By JOHN L. SHEK, M.D.
Saginaw

This is a report of a case of traumatic rupture of thoracic duct resulting in chylothorax. The injury was sustained in a fall from a hay mow. The anterior chest wall hit the ground first. It is felt that due to the relative rarity of chylothorax resulting from a non-penetrating and seemingly insignificant injury to the chest that it might be worthwhile to register this experience in the literature.

The patient, V.H., aged 61, was seen by Dr. Thomas Baker of West Branch on March 18, 1964, shortly after he sustained the above-described injury. The patient stated that he walked away from the fall. Except for some soreness over the right anterior chest, there was no sign of serious injury. A chest x-ray revealed no abnormality. Physical findings were limited to local tenderness over the right hypochondrium and the patient was sent home on analgesics only. In the evening of 3-25-64, the patient returned because of acute shortness of breath gradual in onset since the injury.

On the fourth day after the accident, he stated that he had a sudden pain in the chest and a coughing spell resulted in expectorating some blood. He had lost at least 10 pounds since the injury. At this time, Dr. Baker found a marked shifting of the mediastinum and complete dullness on the right side. X-ray of the chest suggested a massive accumulation of fluid in the right pleural cavity. Pulse was 120, B. P. 100/80 and respiration, 40. The patient was immediately transferred by ambulance to St. Luke's hospital in Saginaw with a diagnosis of massive hemothorax.

Upon admission, the patient was emaciated and had the appearance of someone with chronic disease, rather than acute injury. He was acutely dyspneic but cooperative. Physical findings were that of a massive effusion in the pleural cavity. The right side was flat to percussion. The maximum apical impulse was along the left anterior axilllary line. There was no tenderness when pressure was applied to the sternum. Because of the acuteness of the condition, it was decided that decompression should be done without delay in the emergency room while getting the operating room ready for thoracotomy to cope with the hemorrhage in the thorax. To our surprise, the fluid drained from the right pleural cavity was bloody stained thick purulent material rather than frank blood. This material came out under pressure and a total of 2¼ gallons was removed.

The patient improved remarkably and a diagnosis of infected hemothorax was made. Since the drainage appeared like staphylococcus pus, the patient was placed on isolation and treated with large doses of antibiotics. The material was sent for smear, culture and cytology studies. A portable film taken the next morning showed complete re-expansion of the right lung with return of mediastinum to the middle. We were impressed by the complete normalcy of the lung with no evidence of any disease as well as the completeness of the evacuation of the fluid as demonstrated by the presence of normal costophrenic sulcus.

The patient was afebrile, feeling well, hungry and with a white count of 12,300 with 72 per cent PMN. This lack of systemic response was blamed on the overwhelming infection of the pleural cavity. The studies of the fluid was reported as "culture: no growth; smear: no organism; cytology: no atypical cells." Believing that the antibiotic must have controlled the infection and for fear of introducing infection to the pleural cavity by prolonged intubation, the tube was removed especially since the drainage had been diminishing.

The patient did well and ate well but did not gain weight. While we were congratulating ourselves over the manner in which this acute empyema was brought under control, he again became increasingly dyspneic. Closed drainage was again instituted and 1½ gallons of whitish creamy material was drained. The "pus" again showed no growth on culture. The patient was again put on isolation and standard treatment for subacute empyema.

He continued to be non-toxic, hungry, afebrile, but losing weight. Drainage amounted to about 1000 cc daily. At this juncture, the incongruity of the clinical picture and response to therapy awakened us to the possibility of chylothorax. The fluid was then sent to the laboratory and identified as chyle. Accordingly, in spite of the extremely emaciated condition of the patient, exploratory thoracotomy was performed. Through a levine tube, ½ pint of cream was introduced into the stomach, hoping to increase the flow of chyle and thus to help to ascertain the location of the rupture of the duct and after ligation to test the secureness of its closure. Upon entering the pleural cavity, another 800 cc of fluid was encountered. There was no evidence of any injury to the chest wall, the rib or the lung. Immediately above the diaphragm

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in the posterior mediastinum, there was an area of ecchymosis about the size of a nickel. A rent about ½ cm. in length was noticed in the mediastinal pleura, and tear-like fluid was seen welling from this area. The thoracic duct was found to be completely transected. Both ends of the duct were then ligated but seepage of tear-like fluid continued, though, greatly diminished.

It was only after mobilization of a short segment of the aorta that adequate transfixion suture-ligatures could be placed to successfully control the oozing of chyle. The area was checked 10 minutes later to ascertain the stoppage. A piece of surgicel was placed here to enhance fibrosis. The chest was then closed after the usual fashion.

Postoperatively, the course was uneventful. The patient received nothing by mouth for 48 hours. The intrapleural tubes were removed 60 hours postoperatively after re-expansion of the lung without fluid collection. He gained weight on a low fat, high protein and high carbohydrate diet and was discharged 10 days after operation.

## COMMENTS

1. The occurrence of traumatic rupture of thoracic duct resulting in chylothorax complicating a non-penetrating chest injury is extremely rare.[1] Goorwitch[2] collected only 33 cases from literature between 1948 and 1955 of traumatic chylothorax. Of these, all but six were due to penetrating wounds of some kind. The exact mechanism of closed chest thoracic duct rupture is not known. Hyperextension of the spine is not believed to be the cause.[4] The mechanism in this case may be on the basis of a "contre-coup" mechanism. The location of the rupture in most cases of traumatic rupture of the thoracic duct not due to operative procedure is immediately above the aortic hiatus of the diaphragm. It would seem therefore the sudden movement of the diaphragm must play an important role in the tear of the duct. It is also felt that among the unknown factors involved the variation of anatomy would list high in importance. In this case, the cephalad end of the duct pointed horizontally to the left; that is, the duct makes a right-angled turn to the right after it enters into the thorax.

2. Diagnosis of chylothorax is easy if the possibility is entertained. Points arousing its suspicion in this case were the incongruity of the clinical picture.

(a.) The lack of systemic response in the form of fever, toxicity, leukocytosis and anorexia.

(b.) Rapid loss of weight and emaciation in spite of good appetite and food intake.

(c.) Lack of organisms in the smear of purulent material.

(d.) Lack of underlying lung disease from the x-ray picture of re-expanding lung. Though acute empyema does occur without underlying lung pathology, it is unusual.

(e.) Lack of blunting of costophrenic angle in the x-ray after the fluid was withdrawn. Chylothorax does not result in heavy peel formation as chyle is not irritative to the pleura.

3. Treatment of chylothorax depends naturally upon its etiology. It is not within the realm of this communication to deal with chylothorax secondary to obstructive lesions such as neoplasm or worms. As far as traumatic chylothorax goes, it is almost accepted that early ligation of the ruptured duct offers the lowest mortality and morbidity. Goorwitch's series showed that the 16 cases treated by methods other than direct ligation, had a mortality of 19 per cent. His other 17 cases treated by ligation had no mortality. Mortality prior to ligation of the ruptured duct and treated by thoracentesis and tubing came to 50 per cent. Campbell[5] and Lampson[3] share the honor of being the first to demonstrate the feasibility of ligation of the duct.

The fear of dire consequence following the ligation of the thoracic duct was further dispelled by Stranahan[7] and Pomerantz.[6] They demonstrated by lymphangiography the richness of collaterals of the thoracic duct circulation and the rapidity of re-establishment of functional collaterals for lymph flow following ligation of the duct. The physical characteristics of chyle do not favor coaptation of the rent in the duct. Chyle is less irritative to the tissue than blood; thus the natural process of tissue reaction and scarring may be less pronounced than is favorable for obliteration and sealing of the rupture.

The fact that pleural cavity is a negative pressure chamber adds to the maintenance of the leak in the duck by a milking and sucking effect with every inspiration. Lowering of the diaphragm during inspiration pumps the chyle out of the abdominal cavity into the pleural cavity by increasing the intra-abdominal pressure.

## SUMMARY

A case of traumatic rupture of thoracic duct and chylothorax complicating a seemingly insignificant non-penetrating chest injury, diagnosed and treated successfully by direct ligation was reported.

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## REPORT OF A CASE:

# Rupture of the Uterus with Ligation Of the Internal Iliac Artery As a Life-Saving Procedure

**BY DONALD C. SWAN, M.D., F.A.C.O.G.**
**SOUTHFIELD**

At any moment in an obstetrician's practice, an unforeseen situation may arise resulting in a life-threatening hemorrhage. Rupture of the pregnant uterus with concomitant blood loss and shock is one of these. It is in just such a catastrophe that the hemorrhage is often difficult or impossible to control by conventional surgical techniques and maternal mortality may ensue. The following case report is presented in order to help make us aware of the ever-present danger of uterine rupture, even in seemingly uncomplicated labors, and of the utilization of the technique of unilateral or bilateral internal iliac (hypogastric) artery ligation as a definitive life-saving measure in cases of this type.

## CASE REPORT

The patient was a 29-year-old white woman, Gravida V, Para 111, Ab. 1, whose last menstrual period was March 12, 1961, and whose expected date of confinement was December 19, 1961. Her prenatal course was uneventful. Total weight gain was 17 pounds. Blood pressure and urinalysis were normal throughout. Obstetrical history included one spontaneous abortion at six weeks, followed by dilatation and curettage. There were three full-term normal pregnancies with uncomplicated labors averaging from six to 12 hours with no report of uterine trauma or cervical lacerations. The infants weighed from 6½ to 8½ pounds.

Past medical history included a tonsillectomy and adenoidectomy at the age of six years, and a dilatation and curettage and colpotomy in November of 1960 for a suspected ectopic pregnancy.

* * *

SHE WAS ADMITTED TO the hospital in early labor at 5:30 P.M. on December 16, 1961. Labor had begun at 3:00 P.M. On admission the blood pressure was 120/86 and pulse 80/min. and regular. The general physical condition was excellent and the uterus was the size of a term gestation with regular strong fetal heart tones. The contractions were weak and ineffective at five-minute intervals and lasting 25 seconds. The fetus was in left occipitoanterior position at minus 2 station and the cervix was only 50 per cent effaced with no dilatation. At 7:35 P.M., the character of the contractions was unimproved. The cervix was 1 cm. dilated with descent of the fetal head to minus 1 station. Pitocin, ½ minim, was given intramuscularly at 7:40 P.M. for stimulation of labor.

At 8:10 P.M., the contractions were of good quality, lasting 45 seconds and occurring at two- to three-minute intervals. The fetal head was at 0 station and the cervix dilated 3 cm. with almost complete effacement. The patient received intravenous Demerol and Scopolamine premedication at 8:15 P.M. At 8:55 P.M., the fetal head was at plus 1 station and the cervix dilated to 6 cm. but contractions were again weak, occuring every four to five minutes and lasting only 20 seconds. Pitocin, ½ minim intramuscularly, was repeated.

Spontaneous rupture of the bag of waters occurred at 9:05 P.M. Strong contractions had resumed and the cervix was completely dilated. The fetal head was still at plus 1 station and fetal heart tones strong and regular.

* * *

THE PATIENT WAS transferred to the birth room and spinal anesthesia, using Xylocaine 40 mgm., was given at 9:10 P.M. At 9:20 P.M., a median episiotomy was performed and spontaneous delivery effected with minimal fundal pressure of a viable term female infant weighing 8 pounds, 2 ounces with an Apgar score of 10. The uterus contracted rapidly and the placenta delivered easily by simple expression five minutes later.

However, both the delivery of baby and placenta were followed by moderate amounts of bright red blood. Immediate examination of the cervix with ring forceps revealed a complete left lateral laceration which, when followed with the examining fingers, was found to extend up the entire left side of the uterine corpus to the cornu uteri. Diagnosis by digital intrauterine exploration was made of an incomplete left intraligamentous rupture of the uterus with resultant left broad ligament hematoma. The patient's clinical condition began to deteriorate.

The blood pressure dropped to 90/50, the pulse rate rose to 120/min. and became weak and thready. The patient complained of chills and exhibited pale, clammy skin and drawn facies with excessive perspiration.

Immediately, venipuncture was performed, blood obtained for type and crossmatch, and intravenous

The advent of antibiotics, adequate blood banks, and a more vigorous surgical approach have produced a decrease in maternal mortality due to uterine rupture from between 30 and 50 per cent to an incidence of less than 10 per cent. A case report is presented to show that through prompt diagnosis of rupture, immediate surgical intervention, and the employment of the technique of internal iliac artery ligation this mortality rate may be further decreased.

Dextran and 5 per cent Dextrose/DW started in two separate veins. Methedrine, 10 mgm., was given intravenously. Transfusion with 0 positive whole blood was started as soon as available. The laceration of the portio vaginalis of the cervix and the episitomy were repaired and the patient transferred to the surgical suite for immediate laparotomy.

* * *

WITH A MEDICAL ANESTHESIOLOGIST in charge, an inhalation anesthetic with endotracheal intubation was given. The peritoneal cavity was entered through a lower abdominal midline incision. Inspection of the contents revealed approximately 600 cc. of free blood in the cavity but most of the hemorrhage (estimated at 1500 cc.) was contained in a huge left broad ligament hematoma extending from the rent in the left side of the uterus up the infundibulopelvic ligament to the lateral pelvic wall. On entering the hematoma and draining its blood content, the patient's blood pressure dropped to 0/0 and remained unobtainable until the left internal iliac artery was identified at the iliac bifurcation and ligated doubly with 00 black silk and 1 chromic catgut at points 1 cm. and 2 cm. from its origin.

The hemorrhage decreased markedly at this point and the blood pressure rose steadily to a level above 90 systolic and remained stable thereafter. A supracervical hysterectomy was then performed and a left salpingo-oöphorectomy done because of the destructive involvement of these structures in the massive hematoma.

In attempting to clamp the torn and actively bleeding vessels in the left paracervical area prior to the hypogastric artery ligation, the left ureter was inadvertently partially transected at a point about 2 cm. from the ureterovesical junction. After hysterectomy, this small defect was closed with interrupted sutures of 0000 chromic catgut in the muscularis, forming a re-anastamosis. Reperitonealization of the entire area was performed and two ½ inch Penrose drains placed retroperitoneally to drain the site of the ureteral injury and brought out through a stab wound about 1-inch lateral to the main incision.

The abdominal cavity was closed properly in layers and dressing applied. The bladder was drained with a No. 16 Foley catheter. The immediate postoperative condition of the patient was apparently satisfactory. The patient received 2000 cc. of positive whole blood and approximately 1500 cc. of intravenous fluids, including Dextran before and during the surgical procedure.

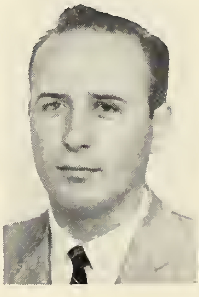
* * *

THE PATHOLOGICAL EXAMINATION of the removed tissue revealed a ruptured uterus of pregnancy. Sections from the area of rupture showed no inflammatory cells, scar tissue, or other lesion indicating the cause for rupture.

The patient's postoperative recovery was completely uneventful. Urological consultation was obtained in order to follow the ureteral injury. Routine postoperative supportive therapy was given along with prophylactic antibiotics and three more units of whole blood. The Foley catheter was removed in five days and the patient was discharged from the hospital on the ninth postoperative day on continued antibiotic therapy and hematinics. Urine continued to drain from the retroperitoneal space at this time but the Penrose drains were removed three weeks later after drainage ceased and intravenous pyelography demonstrated complete healing of the ureter with no disturbance in renal function.

## DISCUSSION

Rupture of the pregnant urteus occurs in approximately one in sixteen hundred deliveries. The incidence is eight times higher in the multiparous group than in the primiparous. Most standard texts show a resultant maternal mortality of from thirty to fifty per cent and a fetal mortality of from sixty to eighty-five per cent[3] although a report from Golden and Betson[4] covering an eighteen-year period after the advent of antibiotics, adequate blood banks and a more vigorous surgical approach shows a maternal mortality of 8.7 per cent and a



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fetal mortality of 41 per cent—results more in line with recent trends.

It is not the purpose of this paper to reiterate what may be found in the standard texts regarding the etiology, mechanism, diagnosis, et cetera of rupture of the uterus. In the case presented it would seem that rupture through an old left lateral cervical tear extending upwards was the most significant etiological factor, although a search of the labor records for the three previous deliveries revealed no history of any such laceration. Injudicious use of Pitocin is often incriminated, especially when given by the intramuscular route. Dwyer[1] goes so far as to say that its intramuscular use should cease.

We fail to concur with his statement and also to believe that the two injections of ½ minim given 1¼ hours apart to augment weakening uterine contractility in our patient were causative factors. Ferguson and Reid[3] cited three cases of rupture in their Boston series as a direct result of excessive manual pressure applied to the fundus during delivery. In each instance the delivery note specifically mentioned that unusual manual force was applied. However, these and five other such cases reported were all in instances where severe shoulder dystocia existed. There was no shoulder dystocia in our case, nor was any excessive or unusual fundal pressure applied.

Regardless of the mechanism of rupture or the etiology in this or any other individual case, this grave complication of pregnancy should never go undetected. The author feels so strongly about this point that routine visual examination of the cervix and digital exploration of the cervix and entire uterine cavity are mandatory in every vaginal delivery and especially those where any untoward degree of third or fourth stage bleeding exists. We have found no increase in morbidity as a result of routine intrauterine exploration.

Another valuable lesson to be learned from this case is that only through sound obstetrical judgment, adequate blood and fluid replacement, antibiotic therapy where indicated and prompt surgical intervention can we hope to reduce to an absolute minimum the maternal mortality from this serious complication.

The technique of unilateral internal iliac artery ligation as employed in this case was a life-saving measure in our opinion. We recommend familiarity with the surgical anatomy of the blood supply to the pelvic viscera and with this technique should the need ever occur. We noted, as did Reich and Nechtow[5] in their series of 82 cases, no ill effects upon the pelvic viscera, including bowel and bladder, from the ligation of this vessel. Collateral circulation to these structures is excellent. We strongly recommend familiarization with this procedure through reference to the excellent presentation of Reich and Nechtow.[5]

## SUMMARY

1. A case of intrapartum rupture of the uterus is presented with favorable outcome to both mother and infant.

2. Maternal mortality was prevented in this case by prompt surgical intervention and through the use of the technique of unilateral internal iliac (hypogastric) artery ligation where otherwise uncontrollable hemorrhage had resulted in a near-fatal circulatory collapse.

3. The author feels the need for the incorporation of this technique into the armamentarium of all those engaged in obstetric and gynecologic practice.

4. To avoid undetected rupture of the uterus, a further plea is made for careful examination of the cervix and digital exploration of the uterine cavity after all deliveries, especially those accompanied by unusual hemorrhage.

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## Birth of a New Drug

"Before enactment of the Drug Amendments of 1962, five to six years were required on the average to place a truly new drug on the market. Now, if the current law and regulations stand, or if there are lacking the right interpretation and regulatory practice, it may well take a decade or longer. The real impact of the 1962 amendments, then, may be felt in the forthcoming decade, not this year or next. Thus, the tempo of discovery and development of new drugs could be set back for years. Other products, too, could be delayed until the log jam breaks. There are some who have expressed the hope that no one dies or suffers unnecessarily during this period for lack of a drug that is not there but could have been if the channels of discovery and distribution were not riddled with hindering laws, regulations, or misunderstanding." —Austin Smith, M.D., President, Pharmaceutical Manufacturers Association, in *Southern Medical Bulletin,* Vol. 51, No. 4.

**The incidence of post-spinal headache in obstetrics can be reduced markedly by giving each patient intravenous fluids, performing lumbar puncture in the lateral decubitus position, and using a 26-guage pencil-point needle. In over 10,000 spinal anesthesias for obstetrical patients, post-spinal headache accured in only 1.5 per cent.**

# The Prevention of Post-Spinal Headache In Obstetrics

**By COLIN CAMPBELL, M.D., Ann Arbor**
**and LOIS MAULDING, Baltimore**

Spinal anesthesia for obstetrical delivery offers the patient a painless delivery without loss of consciousness. The physician has excellent operating conditions and can be sure that he will not deliver an anesthetized infant. With improvements in anesthetic techniques, serious or permanent complications of spinal anesthesia have become rare. Nevertheless, some patients refuse spinal anesthesia because of the fear of post-spinal headache.

Four improvements in anesthetic technique have been used to reduce the incidence of post-spinal headache. They are: (1) the use of small bore needles, (2) the use of pencil point needles, (3) the use of lateral decubitus position for lumbar puncture, and (4) the use of adequate hydration during labor. The purpose of this study is to present a series of cases in which all four of these improvements in anesthetic technique were used in an effort to reduce the incidence of post-spinal headache.

## MATERIALS AND METHODS

The patients discussed in this study are all of the patients delivered at the Hospital for the Women of Maryland from July 1, 1957, through June 30, 1961.

Spinal anesthesia was given to the primigravid patient late in the second stage of labor and to the multigravid patient late in the first stage of labor or early in the second stage. Lumbar puncture was performed with the patient in a lateral decubitus position, after her back had been prepared with a tincture of benzalconium solution which was allowed to dry on the skin. The area to be punctured was wiped with a sterile gauze sponge so that no benzalconium would be introduced along the needle track. In most cases, the lumbar puncture was performed with a 26-gauge pencil point needle. As soon as the anesthetic solution was injected and the needle removed, the patient was turned to the supine position. The level of the spinal block was adjusted by the degree of table tilt. The head of the table was usually elevated 10 to 15 degrees from the horizontal. The height of the spinal block was ordinarily adjusted to dermatome levels between T8 and T11.

As soon as the patient was placed in the supine position, an intravenous infusion of 1000 ml. of 5 per cent glucose in quarter normal saline solution was started through an 18-gauge needle. Blood pressure and pulse recordings were made at approximately one-minute intervals until the anesthetic level was set; recordings were made at 5-minute intervals thereafter. The fetal heart rate was monitored during this time.

Anesthesia for private patients was given by members of the private anesthesiology staff; house patients were given anesthesia by members of the house staff under the supervision of an anesthesiologist. Each patient received at least 1000 milliliters of intravenous fluid before leaving the delivery area. If there were no obstetrical complications, patients were allowed to assume any com-

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Doctor Campbell is assistant professor of Obstetrics and Gynecology, University of Michigan, and Miss Maulding is with the Department of Medical Statistics, Hospital for the Women of Maryland.

From the Departments of Obstetrics-Gynecology and Medical Statistics, Hospital for the Women of Maryland, Baltimore, Md.

fortable position in bed and were permitted up 8 to 12 hours after delivery.

Since headache is a common symptom in any general population, certain ground rules for making the diagnosis of post-spinal headache were adopted. In order to make the diagnosis of post-spinal headache, headache had to occur after spinal anesthesia was given or attempted. If there was no relationship between the headache and the upright position, the diagnosis of post-spinal headache was not made unless the patient had stiff neck accompanying the headache. Any headache which fit the criteria was called a post-spinal headache, no matter how mild or how transient it might have been. A post-spinal headache was considered to be severe if the patient did not have relief by the use of an abdominal binder, codeine in 32 milligram doses, and a high fluid intake. A headache was also considered to be severe if the patient was in such distress as not to wish to be up and about. Anesthesia consultation was requested for all patients with severe post-spinal headache.

In order to assure that the diagnosis was correctly made in each case, patients were asked a series of questions by the Resident Obstetrician during his rounds. Each patient was first asked how she felt. If the patient did not complain of headache, she was then asked if she had any aches or pains. If the patient still did not complain of headache, she was asked specifically if she had any abdominal pain, episiotomy pain, breast pain, or headache. A patient who answered "No" to all these questions was considered not to have a headache.

If the patient complained of headache, she was asked if there was anything she could do to relieve the headache, or if anything made the headache worse. If the patient did not volunteer any relationship to position, she was then asked if the headache was worse when she sat up or better when she lay down. If the answer to all these questions was "No" the patient was asked if her neck was stiff. If the answer was "No" the patient was not considered to have a post-spinal headache. If the patient answered "Yes" to any of the above questions, the diagnosis of post-spinal headache was made.

The progress record in the patient's chart has a special notation for post-spinal headache and has space for writing ordinary progress notes. When the information is to be recorded permanently in an information retrieval system, the recorder examines the post-partum progress note sheet and also the nurse's notes; it is most unlikely that any cases of post-spinal headache were missed.

The information on the chart was transferred to a statistical code sheet by a resident physician; a member of the Medical Statistical Department made an IBM punch card from the code sheet. Post-spinal headache is one of the punches on the IBM card. In every instance where the diagnosis of post-spinal headache was made, the author has examined the entire chart for this study.

Minor changes in anesthetic technique were made from resident year to resident year. These changes may have influenced the incidence of post-spinal headache. They are outlined below:

1. *Resident year, 1957-58.*—Three spinal needles were available on the tray during the first six months of this resident year. They were 26, 24 and 22-gauge pencil point needles on each tray. All members of the Anesthesia and Resident staffs were encouraged to use the 26-gauge needle and to perform the lumbar puncture with a larger bore needle only if they were unable to perform the puncture successfully with the 26-gauge needle. During the first few months of this resident year, a study comparing dibucaine and lidocaine was in progress. After completion of the study, lidocaine only was used for spinal anesthesia.

2. *Resident year, 1958-59.*—During this resident year, lidocaine only was used for spinal anesthesia, and there were 26- and 24-gauge pencil point needles available on each spinal tray.

3. *Resident year, 1959-60.*—During this resident year, a study comparing 26-gauge pencil point needles with a 25-gauge disposable bevelled point needle was done. The incidence of post-spinal headache, which had been about 1 per cent with the 26-gauge pencil point needle, was found to be 5 per cent with the 25-gauge bevelled needle; so the study was abandoned. Late in the winter of 1960, each spinal tray was made up with two 26-gauge pencil point needles. From that time on, anyone who wished to do lumbar puncture with a larger bore needle had to ask specifically for the needle.

4. *Resident year, 1960-61.*—During this resident year all lumbar punctures were performed with the 26-gauge pencil point needle, with the exception of the occasional patient in whom the spinal canal could not be entered with this needle. Lidocaine was used for spinal anesthesia throughout the year.

## RESULTS

An information retrieval system using punch cards and an IBM sorter has been in use at the Hospital for the Women of Maryland since July 1, 1957. From that date until June 30, 1961, 12,249

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### Article Abstracted

The article, "Clues to Diagnosis of Alcoholism" by Richard C. Bates, M.D., Lansing, in a recent issue of Michigan Medicine, has been highlighted in a publication of the Washington State Department of Health. Reference to the article was made in Vol. 5, No. 3, of *Focus on Alcoholism.*

TABLE I. INCIDENCE OF SPINAL ANESTHESIA AND POST-SPINAL HEADACHE

| | |
|---|---|
| Total Deliveries | 12,249 — 7/1/57 - 6/30/61 |
| Spinal Anesthesia | 10,553 = 85% of 12,249. |
| Post-Spinal Headache | 159 = 1.5% of 10,553. |
| Severe Post-Spinal Headache | 12 = 0.105% of 10,553. |

TABLE II. INCIDENCE OF POST-SPINAL HEADACHE BY RESIDENT YEAR

| | | |
|---|---|---|
| 1957-58 | 21 in | 2496 = 0.84% |
| 1958-59 | 27 in | 2683 = 1.04% |
| 1959-60 | 86 in | 2670 = 3.22%* |
| 1960-61 | 25 in | 2704 = 0.925% |
| Total | 159 in | 10,553 = 1.5% |

*1959-60 is the year during which the 25-gauge bevelled point needle was used. Twenty-two of the 86 headaches followed the use of this needle. In the remaining 64 cases, a disproportionately high number of patients had multiple attempts at lumbar puncture. The difference in the incidence of headache between this year and the other three years is very highly significant (Standard Error of Difference is 0.105 per cent; actual difference is 2.28 per cent or 20 times the Standard Error of the Difference).

deliveries were done. Anesthesia was administered in 11,911 cases. 10,553 spinal anesthetics were given for the 12,249 deliveries. Eighty-five per cent of all deliveries were done under spinal anesthesia, and 88.5 per cent of patients who had anesthesia were given spinal. The incidence of post-spinal headache was 156 headaches in the 10,553 spinal anesthetics. Three additional patients developed headache after spinal anesthesia was unsuccessfully attempted; these three cases are charged against the spinal group. The total incidence then becomes 159 headaches in 10,553 spinal anesthetics, or 1.5 per cent. Two patients had post-spinal headache twice, but in neither case was the headache severe.

Spinal headache was considered severe in 12 cases, and in each of these anesthesia consultation was obtained. The incidence of 12 severe headaches in 10,553 spinal anesthestics is 0.105 per cent.

One patient was re-admitted to the hospital the day following discharge. The patient had not developed a headache in the hospital, but began to complain of severe headache at home. After readmission she was seen by the anesthesiologist who, while in some doubt as to whether the headache was spinal in origin, decided to make the diagnosis of post-spinal headache on the basis of the patient's complaints of stiff neck. This patient improved with narcotic drugs and rest. Intrathecal and epidural saline solution was administered to nine of the remaining 11 patients who had severe post-spinal headachesa.

In the resident year 1959-60, the incidence of post-spinal headache was 3.22 per cent as compared to 0.938 per cent in the other three years. The difference is probably due to the use of a 25-gauge bevelled point needle in this year and a very high incidence of multiple attempts at lumbar puncture.

Using the IBM sorter, cases were separated by maternal age, parity, length of labor, and pregnancy and puerperal diseases. No relationship to parity, length of labor, puerperal diseases, or most pregnancy diseases was present.

Maternal age of 24 years or less was associated with an increased incidence of headache (79 headaches in 4,140 cases, as opposed to 80 headaches in 6,413 cases in the group 25 years or over. P is less than .05).

Antepartum anemia was associated with an increase in the incidence of post-spinal headache, but the difference is not statistically significant. Seven of the 159 women with post-spinal headache had antepartum anemia; 257 women with anemia in the group of 10,394 who had spinal anesthesia had no headache (P is between 0.1 and 0.2).

## CONCLUSIONS

The incidence of post-partum post-spinal headache need not deter one from using spinal anesthesia for obstetrical delivery. If the lumber puncture is performed with the patient in the lateral position, small bore needles with a pencil point are used, and each patient is given intravenous fluid therapy, a very low incidence of headache will result. In this series, the change from a 26-gauge needle with a pencil point to a 25-gauge needle with a bevelled point led to a considerable increase in the number of post-spinal headaches.

Since the incidence of headache also went up when multiple attempts at lumbar puncture were made, one might conclude that if lumbar puncture cannot easily be done with the 26-gauge needle, either someone else should attempt the procedure, a 24-gauge pencil point needle should be used, or both should be done.

Spinal anesthesia is used so frequently at the Hospital for the Women of Maryland because obstetricians and patients alike have confidence that unpleasant after-effects are very unlikely to occur.

## SUMMARY

1. 10,553 spinal anesthesias were given for 12,249 deliveries at the Hospital for the Women of Maryland from July 1, 1959 through June 30, 1961.

2. 159 patients had post-spinal headache for an incidence of 1.5 per cent of the 10,553 spinal anesthesias.

3. There were 12 severe post-spinal headaches (0.105 per cent of the 10,553).

4. The very low incidence of headache was achieved by using small bore needles with a pencil point, performing lumbar puncture in the lateral

*(Continued on Page 116)*

# Bulletin

The Michigan Nurses Association and the Michigan State Medical Society have jointly and cooperatively developed the following new language to be added to the definition of nursing practice in proposed new Michigan Nursing Practice Act: "Selected acts delegated to unlicensed persons by licensed physicians, dentists or registered nurses in the performance of their professional functions and performed under the delegation and direction of the licensed physician, dentist or registered nurse shall not constitute the practice of nursing."

In view of this joint action, MSMS' position with respect to the proposed new Nurse Practice Act will no longer be that reported on January 22, 1965. Detailed clarification will be incorporated in the next issue of "Medigram."

Each month these four colored pages carry late-breaking news as an added service of Michigan Medicine to the members. A late deadline permits Michigan Medicine to insert these four pages as the journal is being assembled.

## Urge County Committees on Medicine and Religion

"Please appoint a committee chairman for Medicine and Religion in your county medical society and report the appointment to the MSMS headquarters."

That appeal is made by Richard L. Rapport, M.D., Flint, Chairman of the MSMS Committee on Medicine and Religion. The committees can help "create interest and desire for physicians and clergymen to develop a common, constructive approach to patients; an approach that should be guided solely to provide care for the 'whole patient.' "

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# Ask Every Doctor Back AMA Proposal

Every MSMS member is requested to support the new AMA effort to provide a program of health care for the elderly that will "be better than Medicare."

MSMS has joined all other state medical societies in participating vigorously in the nation-wide educational effort.

Every member has had information from the AMA which included the statement by Donovan F. Ward, M.D., AMA President, before the National Conference on Kerr-Mills in Chicago, January 9. Brochures, speech outlines, etc., are all being made available to every member.

* * *

THE AMA IS EAGER that the American people be acquainted with the merits of the expanded Kerr-Mills approach and to attempt to persuade Congress to adopt it. The AMA points out that "this is a positive program within the framework of the Kerr-Mills Law which is intended to provide help to the elderly who need help and to make it easier for them to get help."

The National Conference on Kerr-Mills reaffirmed the conviction of the medical profession that the Kerr-Mills Law is sound in principle. In Michigan, it can be pointed out that MSMS supported the initial legislative bill—the first in the nation—and has actively supported the improvements. Last year, almost $31 million in health care was provided those over 65 through the Kerr-Mills machinery in Michigan.

* * *

THE AMA PROPOSAL outlines a sound, sensible and workable health care program which will accomplish far more than would be possible under the so-called Medicare social-security tax program. And the AMA proposal has none of the attendant evils of unpredictable expense or invasion of medical pactice by the federal bureaucracy. The AMA plan also seeks to utilize Blue Cross and Blue Shield plans and health insurance companies as intermediary agents—to provide the policies protecting the elderly from illness costs.

MSMS members must explain to their patients and friends that the AMA approach would have those over 65 purchase through the private carriers a wide spectrum of medical, surgical and hospital benefits and then pay all or none of the costs depending upon their incomes. For individuals with incomes under the specified minimums, the state health departments would pay the entire cost.

* * *

THE AMA AND MSMS is suggesting four specific ways that each member may effectively participate. Each county medical society is urged to conduct four phases of the Operation Hometown project:

1. Members should contact members of Congress—through letters, telegrams, telephone and also personally.
2. Members should distribute pamphlets to help explain the Kerr-Mills approach.
3. Members should serve on speakers bureaus and also help to get MD speakers before their civic, fraternal and community organizations.
4. Membership should write letters to their editors, should participate in radio and television programs, and participate in all other educational efforts.

The AMA has declared, "We believe that a majority of the House Ways and Means Committee may be favorably disposed to recommending amendments to the federal Kerr-Mills Act, and we believe it may be possible to persuade members of the Committee and Congress to accept the AMA proposal."

Each member must help.

# Hospital Building Plan for Michigan Ready for Capitol

The Michigan Advisory Hospital Council, a statutory council advisory to the state health commissioner, at a meeting on January 7, reviewed and approved the 17th annual revision of the Michigan State Plan for Hospital & Medical Facilities Construction and recommended the plan be submitted to the Surgeon General for approval.

The plan is the administrative document for distribution of Federal funds allotted to the state for health facility construction.

Michigan allotment for the current fiscal year totals \$8,272,050—\$5,689,000 for hospitals and health centers, \$1,475,000 for long-term care facilities, \$737,897 for diagnostic and treatment centers, and \$369,000 for rehabilitation centers. The state's allotment is slightly less than the allotment for the previous year.

Last year a total of 22 projects were placed under construction in Michigan, 14 projects were completed, and 30 were in various stages of planning.

## *Auto Accident Article Appreciated by Cornell*

Dear Editor,

We are grateful to the Michigan State Medical Society for the continued interest and effort on our behalf.

The scientific article, "America's Number One Epidemic," about the Automobile Crash Injury Research project which appeared in your October issue of MICHIGAN MEDICINE is very much appreciated.

*William D. Coleman, Field Rep.*
Automobile Crash Injury
Research
Cornell University,
Buffalo, N. Y.

Detroit Mayor Jerome P. Cavanagh, third from left, featured speaker at the luncheon for the Twelfth Annual Symposium on Trauma, January 6, exchanges views with, left to right, Franklin V. Wade, M.D., Detroit, Chairman, Michigan Committee on Trauma of the American College of Surgeons; Armen Shekerjian, M.D., Detroit, President, Detroit Academy for the Surgery of Trauma, and Joseph L. Posch, M.D., Detroit, Chairman, Detroit Regional Committee on Trauma.

# *Detroit Medical Center Progress Lauded by Mayor*

An appeal for "continued cooperation" in the development of the new Detroit Medical Center was made by Mayor Jerome P. Cavanagh in his address before the Twelfth Annual Symposium on Trauma in Detroit, January 6.

The event was sponsored by the Detroit Regional Committee on Trauma, the Michigan Committee on Trauma, Wayne State University and the Detroit Academy for the Surgery of Trauma.

Mayor Cavanagh, in his closing remarks, declared:

"We are encouraged by the potential of our Medical Center. We have witnessed the federal and city government working together to acquire and clear the land. We have witnessed the hospitals and university working together to plan and build the physical facilities which will be used by the medical profession to begin a new era of progress in medical care, teaching and research.

"Let us continue our cooperation."

The plan for the medical center, he said, "symbolizes our growing concern for human renewal, for it is here in this center that we shall continue and intensify our efforts to match the achievements you have made in medicine to the afflictions of our people."

The Mayor traced the developments and pointed out that "the concept for the Medical Center materialized in 1955 with the formation of the Detroit Medical Center Citizens Committee." He explained the work of the City Plan Commission and the City Housing Commission and the several federal urban renewal programs "to lessen the city's financial burden."

The physicians were told by the Mayor that "The master plan for our Medical Center is designed to accomplish four important goals:

"1. The creation of a carefully planned road and land use pattern, including the elimination of unnecessary streets.

"2. The consolidation of existing city blocks to allow for larger units of land to facilitate construction of large improvements.

"3. The maximum separation of pedestrian and vehicular traffic, and

"4. The greatest possible use and enhancement of existing institutions in the area."

# Medical Service Given Legislators By Ingham Doctors

Dr. Robert H. Trimby, President
Ingham County Medical Society
Lansing, Michigan

Dear Doctor Trimby:

Thank you very kindly for your letter of the 10th, and the information contained therein.

I am appreciative of this fine service you are offering and want to thank you for making it available to me. Enclosed, herewith, you will find the enclosure and again thank you for your kind thoughts in my regard, I am,

Very truly yours,
*Rep. Charles O. Zollar*
Benton Harbor

* * *

This letter is typical of the comments received by the Ingham County Medical Society and the Michigan State Medical Society as the medical profession seeks "to be sure that no member of the Michigan Legislature shall fail to receive high quality medical care because he is away from his own doctor of medicine."

Letters from Doctor Trimby were sent to each member of the Michigan State and Michigan House of Representatives. The letter offers to provide a wallet card of vital information and a list of Ingham physicians who would answer emergency calls of Legislators.

The letter also explained that "a well-equipped first aid facility has been established in the Capitol Building and is staffed by a Registered Nurse while the legislature is in session."

This entire project of (1) a "congratulatory letter" to the legislator, (2) the preparation of an emergency card, and (3) the first-aid facility is an annual public-service activity of MSMS and the Ingham Society.

## MATERNAL HEALTH CONFERENCE, MARCH 11-12

Final plans for the Conference on Maternal and Perinatal Welfare at Flint, March 11-12, are double checked by Wm. W. Jack, M.D., seated at right, Grand Rapids, Chairman of the MSMS Committee on Maternal Health, with other leaders of the conference. Left to right are Goldie B. Corneliuson, M.D., Lansing, Director, Division of Maternal and Child Health, Michigan Department of Health; T. N. Evans, M.D., Ann Arbor, Professor of Obstetrics-Gynecology, University of Michigan; and Hermann A. Ziel, Jr., M.D., State Health Department Obstetrical Consultant.

(See article about the Conference on page 117.)

## High-Limit Accident Insurance Offered

An enrollment card has been sent to every member for the new MSMS Group Special Accident Insurance Plan.

The new high-limit accident insurance plan was developed by the MSMS Committee on Professional Insurance Plans, Fredrick Weissman, M.D., Detroit, Chairman. The Committee, which had received a number of requests for such a policy, believes there is a definite need for this new MSMS service to members.

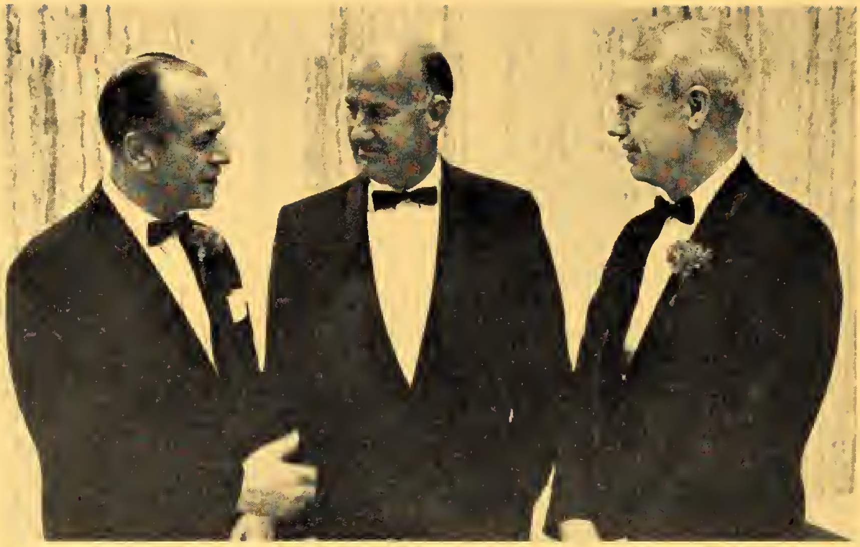
If you misplaced your informational brochure or enrollment card, you may obtain another from MSMS, Box 152, East Lansing.

## Thyroid Workshop At Wayne, Feb. 24

A Thyroid Workshop will be sponsored by the Wayne State University School of Medicine, Wednesday, February 24, at the Wayne County Medical Society Auditorium. Chairmen will be Robert Mack, M.D., and Nelson Taylor, M.D., both of the WSU Department of Internal Medicine.

The program, to begin at 9 a.m., will deal with "Radioiodine Thyroid Diagnostic Procedures," "Chemical and Other Thyroid Diagnostic Procedures," and "Autoimmune Thyroiditis and Pathogenesis of Hypothyroidism."

The Merck, Sharp and Dohme Lecture at 4 p.m. will be given on "Hyperthyroidism" by Leslie Degroot, M.D., Harvard Medical School and Associate Editor of the *New England Journal of Medicine.*



AT LEFT—Edward R. Annis, M.D., center, Past-President of the AMA, speaker at the Annual Dinner Meeting of the Genessee County Medical Society at Flint, January 7, confers with Lawrence G. Bateman, M.D., left, Genessee President, and Dr. Hira E. Branch, M.D., right, Immediate Past President. More than 350 heard Doctor Annis declare that the American people may have legislation "foisted upon them that even legislators would not have if they knew and understood the medical profession's story." *(Flint Journal Photo)*

Doctor Annis also addressed the Kalamazoo Academy of Medicine, Tuesday, January 19.

## *New President For Wayne Sees Medical Greatness*

"It is in the cards for Wayne and Detroit to have one of the great medical centers in the United States. The size of the medical center area, the fine facilities, and the cooperation with other institutions almost guarantees its future."

Those comments were made by William R. Keast in his first interview January 2 in Detroit as the newly-appointed President of Wayne State University.

President Keast, 50 years old, who has been academic Vice-President of Cornell University, will succeed Clarence B. Hilberry, who retires.

## Woman's Auxiliary Program Set Feb. 19

Remind your wife!

Yes, the Annual Woman's Auxiliary Winter Meeting will be held at the Whittier Hotel in Detroit on February 19.

Mrs. Milton S. Weed, Detroit President of the Michigan Auxiliary, reports the program will begin sharply at 9:30 a.m.

The winter meeting program (formerly held in conjunction with the MCI) will cover Legislation, Health Careers, AMA-ERF, Mental Health and many other topics.

JACKSON—The Jackson Citizen Patriot recently carried photos of new equipment in the pediatrics wards of the Foote and Mercy Hospitals—the equipment purchased from the Oral Polio surplus. The Jackson County Medical Society gave each hospital $11,594 to split the surplus proceeds from contributions.

* * *

DETROIT—A Myrtle Wreath Achievement Citation was presented January 12 by the Detroit Chapter of Hadassah to Reuben L. Kahn, Sc.D., University of Michigan professor emeritus of serology. He was cited for his contributions in Medical research, advancements in Medicine and for his interest in Israel.

* * *

CHICAGO—The AMA is advancing plans for its 1965 Annual Meeting in New York City, June 20-24.

BELOW—Ernest B. Howard, M.D., right, Assistant Executive Vice-President of the AMA, discusses the current AMA legislative efforts with Clark W. Royer, M.D., left, new President of the Calhoun County Medical Society, and George W. Slagle, M.D., Immediate Past-President, before his speech at the Calhoun meeting January 5. Several members from adjacent counties were guests. *(Battle Creek Enquirer and News Photo.)*

# MSMS Centennial Series: 1953, 1954

## *Beaumont Memorial Dedicated*

*Leading up to the MSMS Centennial in 1965,* The Journal *is printing a series of articles by William J. Stapleton, Jr., M.D., Detroit, who is the MSMS Historian. This series began in the September, 1963, number of* The Journal *and will continue through August, 1965.*

### 1953

Among the things of importance during the year 1953 was the following, which shows how Michigan is always working for the health of the community, viz.:

Developed originally by the MSMS in 1947, the Annual Michigan Rural Health Conference now is one of the outstanding meetings of its kind in the United States. The 6th Annual Conference, held this year at the Kellogg Center on January 16-17, had a registration of more than 400 persons.

The Council on January 30-31 in Detroit, heard a progress report on the Beaumont Memorial Restoration by Otto O. Beck, M.D. Approximately one-third of Michigan's doctors had contributed a total of $27,113.90.

* * *

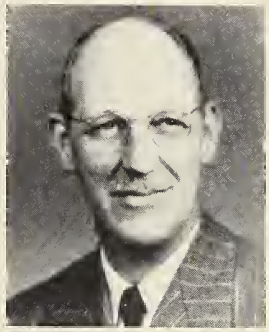
IDEAS ON PRACTICAL public relations were carried back to Michigan's component county medical societies by the 111 MSMS and Woman's Auxiliary members who attended the MSMS Public Relations Conference in Detroit on February 1.

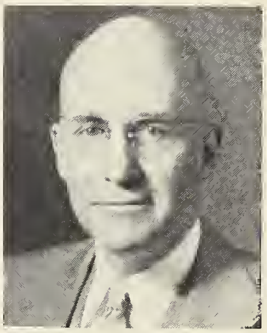
Norman F. Miller, M.D., Ann Arbor, was recognized for his outstanding contributions to cancer education and research at a luncheon sponsored by the MSMS Cancer Control Committee in Detroit on March 12.

The 1953 Michigan Clinical Institute in March had an attendance of 2,283.

The Ingham County Medical Society celebrated its Silver Anniversary.

* * *


R. J. Hubbel, M.D.
President, 1952-53


L. W. HULL, M.D.
President, 1953-54

THE CORNERSTONE of the Beaumont Memorial House was laid on July 17, with the dedication of the completed building set for July 17, 1954.

A special vote of thanks should go to all members of the House of Delegates for the time and thought they gave to the workings of our Society.

The 1953 House of Delegates authorized the publication of a pamphlet to outline the history and objectives of the Medical Assistants Society, and approved the establishment of courses for the education of medical assistants throughout the state.

* * *

THE ANNUAL SESSION in Grand Rapids drew 3,266. Among the "firsts" were the first General Practice Day, the first meeting of the Michigan Chapter, American College of Surgeons, and the first Beaumont Lecturer. The Biddle Lecturer was U. S. Senator Homer Ferguson.

The Council in September approved the recommendation of the Awards Committee that the MSMS create an award for outstanding reporting of medical progress, and presented the award to Jack Pickering of the *Detroit Times* for outstanding contributions to public understanding of medical and health progress.

A Medico-Legal Institute, under the sponsorship of the State Bar of Michigan, was held December 10-11 in Detroit. Doctors of Medicine, lawyers, professors, and teachers of legal medicine and law participated.

* * *

INVITATIONS during the year to become a member of the Advisory Committee to the Michigan State Traffic Safety Federation and also to become a member of the National Society for Medical Research were accepted.

A $200,000 campaign for a Medical Library Fund was underway by the Alumni Association of the Wayne University College of Medicine.

With the guidance and advice of Mrs. William Mackersie, President of the Woman's Auxiliary to the MSMS, a Woman's Auxiliary to the Ontario

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*The Author*
WILLIAM J. STAPLETON, JR.
M.D.
MSMS Historian

Medical Association in the neighboring province of Canada was formed.

As usual, as one goes over the year's work, it shows that the Michigan State Medical Society is in the forefront for the health of our people.

* * *

## 1954

The other day I was talking to Dr. Harry Dibble, and I said to him, "Harry, have you seen 'Bud' Hull lately?"

"Didn't you know? Bud has retired and is living on one of those lakes out in Oakland County," replied Doctor Dibble.

We want to say Bud is a fine chap. I met him in World War I in France and have known him ever since. Bud, or "Buddy" as some of us called him, has retired to an earned rest. He was a real gentleman, an excellent surgeon in his specialty, beloved by all of us, and especially by his patients. Bud, we all hope you will have a wonderful time in your retirement. You can now do all those things you couldn't do as a busy man of urology.

* * *

THE HIGHLIGHT OF 1954 was the dedication of the Beaumont Memorial on Mackinac Island. The dedication ceremonies were on July 17, when MSMS officially presented the Memorial to the State of Michigan.

The July 17 event climaxed a decade of planning. It was Otto O. Beck, M.D., who, during his term as MSMS President in 1951-52, adopted the memorial as a major project. He then continued in 1952-53 as chairman of the Beaumont Memorial Restoration Fund campaign.

Doctor Beck, in a special article in the dedication program booklet, declared, "The Beaumont Memorial will be a beacon to remind the public that medical progress is rooted in the history of this state. Michigan Doctors of Medicine are privileged to honor this heritage. Let us make the most of this opportunity, and in doing so, we will honor our medical profession, the people of Michigan, the State of Michigan, and give the Beaumont Memorial the place it deserves among the medical shrines of the world."

* * *

IT WAS MSMS President Hull who formerly presented the memorial to the state, and it was accepted by W. F. Doyle, resident commissioner, Mackinac Island State Park Commission.

The 1954 Michigan Clinical Institute broke all attendance records with a total of 2,503 registrations. The **Detroit News** and two of its science reporters, along with five other Michigan newspapers, received special MSMS awards at the time of the 1955 Michigan Clinical Institute for their services in promoting better public understanding in the field of health.

* * *

THE MICHIGAN HEALTH Council, which was asked in 1953 to take over the MSMS placement program, reported in July that 47 doctors had been placed already.

President Hull presented to the Mid-Summer Session of The Council a gift from John Hopkins, D.D.S., of Detroit—Paul Revere's dental instrument—for display in the Beaumont Memorial. The Council adopted a motion recognizing the trends in the supervised training of practical nurses and their valued services to the public, urging that the extension of such a training program be encouraged.

Establishment of the Medical Examiner System was approved by the voters of St. Joseph County on August 3. Leading up to the election, a three-month educational campaign was carried on by the St. Joseph County Medical Society.

One of the resolutions of the 1954 House of Delegates dealt with civil defense. The delegates resolved that "this House of Delegates, realizing the urgency, direct constituent society to assume its responsibility and organize immediately a medical civil defense program in support of the State Plan."

* * *

RECOGNIZING THE PR opportunity with the opening of WPAG-TV in Ann Arbor, the Washtenaw County Medical Society, in cooperation with the MSMS, went on the air in November with one of the first regularly scheduled local programs over the new station. The MSMS provided motion pictures used on the weekly half-hour show entitled "Drama of Life."

A Group Health and Accident Insurance for members, approved by the 1953 MSMS House of Delegates and underwritten by the Provident Life and Accident Insurance Company, is effective now.

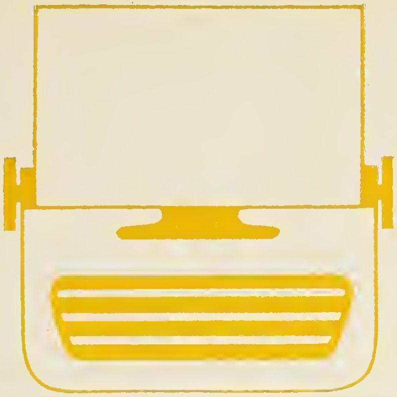
The Michigan Cancer Co-ordinating Committee got underway in 1954, with representation from the American Cancer Society, Michigan Division, the American Cancer Society, Southeastern Michigan Division, the Michigan Department of Health, the Michigan Health Officers Association, the Michigan State Dental Association, and the Michigan State Medical Society. The Cancer Co-ordinating Committee's program of integration, to eliminate duplication and to stimulate concentrated activity in cancer control, bodes well for the future joint effort of cancer works in the state.

## ***Offer RF Cards***

The *ad hoc* subcommittee of the Rheumatic Fever Committee of the Michigan Heart Association, in cooperation with the Cardiac Control Committee of the Michigan State Medical Society, has prepared a revised set of Desk Reference Cards for Rheumatic Fever that will be made available free to physicians, residents and interns.

Thirteen Michigan physicians, under the chairmanship of Frank D. Johnson, M.D., Flint, prepared the new set which is divided into 18 topics and deals in detail with diagnosis, treatment and prevention. The cards are 3 by 5 inches.

For a set, write to RF Card, Michigan Heart Association, 13100 Puritan, Detroit 48227.



# EDITORIAL VIEWS

## Hats Off to MHC

The Michigan Health Council, a voluntary educational organization to advance the health of the people, is now in its 22nd year. Established on August 23, 1943, by officers of the Michigan State Medical Society, Michigan Hospital Association, Michigan Medical Service, and Michigan Hospital Service, it has grown into a most effective program.

The services provided by the Health Council are briefly reviewed in its 21st Annual Report for 1964. Of particular interest to physicians are the activities in professional placement and in recruitment for health careers.

The M.D. Placement Service was established in 1953, and is offered free of charge to doctors looking for communities in which to practice and to communities looking for doctors. In 1964, 66 M.D. placements were made in the State. Since 1953, according to the Annual Report, 636 doctors of medicine have used the service in selecting a Michigan community. It is of genuine importance to note that more than half of these physicians had received their medical degrees from out-of-state medical schools.

The roster of the M.D. Placement Service has a current listing of 140 general practice opportunities, with many of these in small Michigan communities where the local doctors feel that there is need for one or more additional physicians.

Recognizing that the production or attraction of physicians will not in itself solve the health manpower problem, and that each physician requires some 10 people in health related professions to assist him, the Michigan Health Council, in 1958, wisely established a Health Careers Program. Under this program, health career conferences have been held on local as well as state-wide levels and health careers exhibits have been widely displayed. The Council has distributed more than 65,000 copies of four illustrated health career booklets and reports that thousands of other brochures covering more than 50 health careers have been provided for interested Michigan students.

Space does not allow adequate coverage for the many other programs but doctors are urged to learn more about the Michigan Health Council. Information about it is readily available through John A. Doherty, executive secretary, at the MHC offices, 712 Abbott Road, P.O. Box 431, East Lansing, Michigan 48824.

Medicine congratulates this valuable ally as it moves into its 22nd successful year!

## Philadelphia Viewpoint

George E. Farrar, Jr., M.D., received his training in Internal Medicine at the University of Michigan. As president of the Philadelphia County Medical Society, he has recently written in that Society's bulletin expressing deep concern that legislation to give hospital care to all persons 65 and older "would result in a collapse of hospital care in this country."

In Philadelphia, Dr. Farrar reports, "A Chamber of Commerce task force has been studying the cost of hospital care. The recommendations of this task force, which includes physicians, hospital administrators, planners, third party payment representatives and others, are of genuine interest to all of us as physicians.

They recommend the following: (1) Adding new acute-disease beds only when they are needed. (2) Adding new chronic-disease beds nearly everywhere. (3) Introducing intensive care and self care units. (4) Improving utilization of existing facilities by such programs as pre-admission diagnostic studies. (5) Making a routine review of the need for hospitalization after a patient has been confined for fourteen days. (6)

Establishing more and better nursing homes. (7) Developing home care programs. (8) Operating hospital diagnostic and treatment facilities seven days a week. (9) Training more paramedical personnel."

In the State of Michigan, efforts are underway toward most of these same target areas. However, we in Michigan should share the concern in Philadelphia, that our efforts to hold down health care costs by greater efficiency and our efforts to provide good care for more people, may collapse if legislation throws heavy added burdens on already crowded acute general hospitals.

The City of Brotherly Love has made an important point.

# Learning to Write

**By CHARLES SELLERS, M.D.**
**Detroit**

A great many people in the United States have difficulty in using the English language to its best advantage. They are not adept in speaking, reading, or writing. They are not illiterates; most of them finished high school but somehow failed to reach college.

For some time there has been a steady decline in attention to speech, rhetoric, and composition in the general educational process. All elementary teachers used to be concerned with these subjects, whereas today special remedial courses are required to overcome glaring deficiencies in previous training.

High school graduates should be better prepared than they are in a number of fields, and most particularly in use of the English language, their mother tongue.

Of course, if their mothers did not teach them good English in childhood they have an added handicap and teachers have great difficulty in changing long established slovenly speech habits.

At any rate, many of them speak incorrectly, read haltingly, and write with great difficulty. They never became interested in the language and its great versatility. They never became enamored with words and their nuances of meaning.

Quite recently, politicians have been taking notice of so-called pockets of poverty, and remarkable as it may seem, some of them recognize the direct relationship of faulty training in school and inadequate education to unemployability and thence to poverty.

Disseminating elementary education to all young persons in the country is an ambitious project. Overcoming inertia, lethargy (if not hookworm) in several areas will be difficult, but it must be attempted. The results could be most far-reaching. We cannot afford pockets of ignorance nor pockets of poverty, and usually they are closely associated.

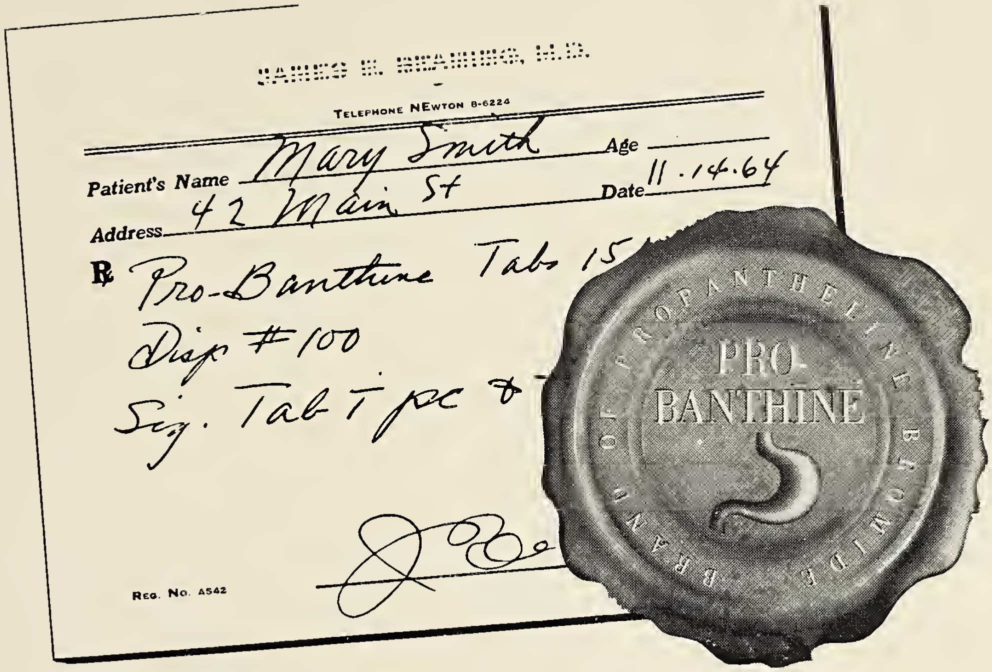
The printing presses of the world turn out a prodigious amount of printed material in a never-ending parade. There is a great variety of books, newspapers, magazines, journals, and inserts with packaged pharmaceuticals.

Someone writes every word of these compilations before they reach the printer. Usually it is done the "hard way," by first acquiring extensive knowledge of the subject material for the anticipated article. The author then organizes the facts, the ideas, and the knowledge by outlining a series of headings. The first draft of actual writing usually is in long hand because the procedure can be done alone as one quietly thinks or composes the material, and it can easily be altered. The second copy is typed incorporating the alterations. The typed page seems to show up poor construction, faulty English, inconsistencies, and inaccuracies in a glaring manner. After the third, fourth, or fifth correction and retyping the material should read more smoothly and may satisfy the author.

The typescript should then be put aside for a week or it might be entrusted to a friendly critic who could criticize the writing without being critical of the author. One more corrected copy in typescript undoubtedly is necessary.

This method seems difficult, never ending, and exhausting, but good writing usually requires some similar procedure. Of course, a genius might dictate or type a fine article directly from conception to the finished product, but very few of us can qualify for such outstanding performance. Alternatives to the long laborious process include turning out a poorly constructed, muddled article devoid of interest or enlightenment.

Learning to write takes perseverance.



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## Computers Busy in Research

More than 150 biomedical research scientists, engineers, and physicians attended a recent conference at White Plains, N. Y., on the use of the electronic computer and nuclear energy in medical research. The meeting was the 6th Medical Symposium sponsored by the International Business Machines Corporation, co-sponsored by the U. S. Atomic Energy Commission's Brookhaven National Laboratory.

During the meeting, researchers from 26 leading medical colleges, clinics and laboratories described a wide variety of current medical studies.

Many of the reports underscored the growing use of the computer in such studies. Researchers described projects in which computers are used to:

. . . simulate the spread of viral infections to help microbiologists better understand the viruses which cause diseases such as influenza and polio.

. . . analyze responses by medical patients to psychological tests and explore the relationship between test profiles and various diseases.

. . . store information from medical textbooks to evaluate new ways of helping physicians diagnose complicated illnesses.

. . . convert all the combinations of words used by doctors to describe patient ailments into codes that are easily stored, processed, and retrieved.

. . . discover rare recessive diseases by tracing genetic linkages among certain "closed" population groups such as the Old Order Amish.

## CONCLUSION: PREVENTION OF POST SPINAL HEADACHE IN OBSTETRICS

*(Continued from Page 106)*

decubitus position, and giving each patient intravenous fluid at the time of delivery.

5. Patients less than 25 years old were more likely to develop post-spinal headache than those over 25 (P less than .05).

6. Patients with antepartum anemia had a higher incidence of post-spinal headache than patients without anemia (the difference was not statistically significant).

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## New Medical Schools

(New York State Journal of Medicine)

The need to provide 3,000 more medical graduates each year over the next seven years shows promise of being met. A current report from the Association of American Medical Colleges (A.A.-M.C.) describes the situation as follows:

In 1959 the Surgeon General's Consultant Group on Medical Education recommended 10,400 M.D. graduates per year by the year 1975 to meet the needs of our expanding population. If the present attrition rates continue, this will mean that United States medical schools must admit 11,700 first-year students in 1971. In the fall of 1963, 8,754 first-year students were enrolled. Thus, over the next seven years, United States medical schools must provide nearly 3,000 more first-year places than presently exist. New places can only be provided in two ways: the creation of new schools (either two- or four-year programs) and the expansion of existing schools.

Commitments have presently been made to establish new schools which will offer an eventual total of something over 800 first-year places. This leaves approximately 2,200 new first-year places that are still needed. Although additional new schools are in prospect, most of these places must result from the expansion of existing schools. While the 12 new schools are still in various stages of development, all except one have appointed chief administrative officers.

Institutions planning programs to meet the requirements of the first two years of the medical curriculum are the University of New Mexico, Rutgers University, Michigan State University, University of Hawaii, and Brown University. Brown University is accepting college freshmen in a six-year program combining premedical and basic medical sciences. Students completing these programs will transfer to the third-year class in other medical schools.

Institutions planning the complete program for the M.D. degree are the University of Arizona, University of California at San Diego, University of Connecticut, Pennsylvania State University, University of Massachusetts, Mount Sinai Hospital, New York, and the University of Texas at San Antonio. Most of the new programs will not admit the maximum enrollment at the opening date. The naming of these schools does not imply that their accreditation status has yet been determined. This is the responsibility of the joint A.M.A.-A.A.M.C. Liaison Committee on Medical Education. As these schools progress in their development, they will be surveyed by representatives of the Liaison Committee prior to consideration for accreditation.

## Michigan Film, A Winner

A "Diploma of Honor" was awarded the Michigan Cancer Foundation film, "Cancer—Life Against Itself", in the International Film Competition sponsored by the Finnish Medical Association in Helsinki this year.

## OUR STATE SOCIETY

# Maternal Health Event, March 11-12; Register Today!

There's still time.

Yes, there is still time to send in an indication that you want to attend the fourth annual Michigan Conference on Maternal and Perinatal Welfare, at Flint, March 11-12.

Registration forms were mailed in mid-January to every MSMS member. You may return the form, or send a note to the MSMS Committee on Maternal Health, a co-sponsor for the event. Joining with MSMS in this event this year are the Michigan Department of Health and the Clara Elizabeth Fund of Flint.

The program at the Pick-Durant Hotel will begin with luncheon on March 11, and continue through an evening dinner meeting; it extends to March 12 from 8:30 a.m. to 1:30 p.m.

Outstanding speakers, announced in the December and January issues of Michigan Medicine, will come from New York City, Syracuse, Chicago, Detroit, Ann Arbor, and Brookline, Mass.

Yes, there's still time.

## Coming in March

Watch for an authoritative article on Brain Tumor, and a most interesting and comprehensive review of unusual causes of intestinal obstructions.

An article on "The Physician's Role in the Sexual Education of Children" should be of interest to everyone, and a review of tuberculosis—yesterday and today—contains information of great interest.

# *Observations on AMA Facilities Planning Conclave*

The official Michigan representative at the First Annual Conference on Areawide Health Facility Planning, held in Miami in conjunction with the AMA annual meeting, was Robert E. Rice, M.D., Greenville, a MSMS alternate delegate, and chairman of the MSMS Committee on Rural Medical Service.

The speakers discussed various areas of experience or interest in the problem of areawide planning. A comprehensive report of the Conference was presented by Doctor Rice to The MSMS Council Dec. 16. Following are several excerpts from his report:

"The measurement of need for facilities is best developed by a community profile obtained from information from various sources such as the Hill-Burton Agency, license bureau, municipal planning agency, education and employment groups, individual hospital reports, hospital association, nurses association, Chamber of Commerce, Bureau of Census, vital statistics, church groups, AMA Directory, county society, Joint Commission on Hospital Accreditation and legislative material.

"The profile points out the strength, the weakness, and the uniqueness of a community. Knowledge of each facility helps all facilities recognize the impact of other community services, such as nursing homes, home care, etc.; it shows relations of other community planning, such as urban renewal, airports, schools, etc.

"Community organization and attitudes about planning are enhanced and need those who are willing to participate and have confidence in the organization and understanding of the evaluation.

"To act without plan is disastrous, to plan without acting is futile.

"There is a need for various groups to educate each other so that there can be a more meaningful target for each group. In the end, the efforts must be integrated. The complex of a city is more like a bunch of grapes rather than an apple.

"The needs of suburbia differ from those that are left or move into the core area. The problem in the core area has often been given up as far as our traditional methods of medical services are concerned.

"Local planning is done by local groups, but funds come from a broader base and the solution must be related to broad principals developed on a broader base, for instance, urban renewal.

"The effectiveness of the physician-patient relationship is not sufficient unto itself. It depends on the availability of the facilities and services. We still have the ability to choose what we want, but this may resolve itself into 'who calls the balls and strikes.'"

# Abstract of MSMS Council Action

## *Meeting of December 16, 1964*

### FAMILY PLANNING

The Council noted that the AMA had adopted a resolution on family planning at its Clinical Meeting in Miami and therefore requested the MSMS Maternal Health Committee to study this matter with possible recommendations regarding a MSMS statement on the subject.

### REPORT OF MICHIGAN MEDICAL SERVICE

MMS President Adler reviewed MMS testimony at the December 15 public hearing on the Blue Cross-Blue Shield proposed change to merit rating before the Insurance Commissioner in Lansing. Doctor Adler also discussed merit rating, certified income amendment, anti-duplication coverage, and frequency-of-use study.

### VOLUNTARY HOSPITAL PLANNING GROUP

The Council discussed with the Executive Director of the Michigan Hospital Association the possibility of MSMS participating in the Hospital Research and Educational Reserve, Inc., which is being formed to develop planning for regional and local health facilities. The Council voted to participate in voluntary planning activities and provide financial support to the Reserve. The Council will nominate several representatives to serve on the Board of Directors, membership and planning council.

### MICHIGAN HEALTH FAIR

The Council received a report regarding the campaign for outside financial support. The campaign did not reach the desired goal and it was further reported that the estimated budget might not cover expenses. A report from tax consultants indicated the necessity of having a charitable organization receive and disburse Health Fair funds and that MSMS, not being a charitable organization, should not get involved in the financial administration of the Fair.

The Council, taking into consideration the above factors, after full discussion decided that in the best interests of MSMS, both from a financial standpoint and relationship with the Internal Revenue Service, the 1966 Health Fair plans must be discontinued.

### POSTGRADUATE MEDICAL EDUCATION ACTIVITIES

The Council approved holding regional clinic days, approved plans for providing postgraduate speakers for individual county medical societies, and raised the honoraria for physicians serving at clinical conferences in the postgraduate program.

### CONCEPT OF MSMS CENTENNIAL

The Executive Director reported on extensive plans being developed for the observation of the MSMS Centennial during the Annual Session, September 19-24, 1965, at Cobo Hall, Detroit.

The Council also authorized the designation of Sunday, September 19, as Medicine and Religion Day, and Tuesday, September 21, as Interns-Residents-Students Day.

### APPOINTMENTS OF COMMITTEES

Chairman Hiscock reported that a new Committee on Medical Aspects of Organized Athletics had been formed. Also, the Committee on Evaluation of Prepaid Medical Services (1964 Resolution 22) had been appointed, with the exception of two additional representatives to come from Wayne County and the designation of a chairman.

### NATIONAL BLUE SHIELD BOARD REPRESENTATION

The Council noted that Michigan Medical Service had informed The Council that Michigan Blue Shield lacked representation on the board of the National Association of Blue Shield Plans. The Council agreed to request additional information from Michigan Medical Service and from the National Association of Blue Shield Plans on this matter.

### ADVISOR TO DETROIT HISTORICAL MUSEUM

Doctor McGillicuddy announced appointment of Wm. M. LeFevre, M.D., Assistant MSMS Historian, as advisor to the Detroit Historical Museum to aid in development of appropriate historical exhibits during the MSMS Centennial.

### ADVISORY BOARD TO SECRETARY OF STATE

The Council approved, upon recommendation of the Highway Accident Prevention Committee the appointment, by the Michigan Secretary of State, of a Medical Advisory Board to review, when necessary, physicians' statements regarding physical fitness to operate a motor vehicle. Nominations for the Board will be transmitted to the Secretary of State.

*(Continued on Page 120)*

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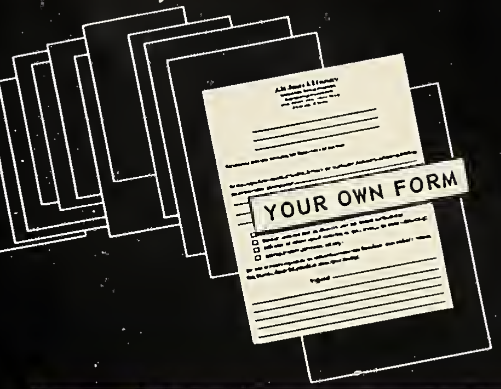

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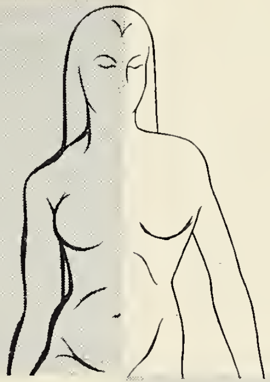

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*(Continued from Page 118)*

### STATUS OF AMA DELEGATES AND ALTERNATES

Speaker Lightbody clarified the status and seniority of the AMA delegation and recommended that procedures for election, dates and terms, and policies for replacement of delegates in the event of a vacancy, be studied by the MSMS Constitution and Bylaws Committe for possible Bylaws clarification. The Council did refer this matter to the Constitution and Bylaws Committee for study.

### REPORTS OF REPRESENTATIVES TO MEETINGS

The Council reviewed a report about the AMA Conference on Disaster Medical Care from its representative, Grant L. Otis, M.D., about the National Conference on Medical Aspects of Driver Safety and Driver Licensing from John R. Rodger, M.D.; and about the Conference on Voluntary Hospital Planning from Robert E. Rice, M.D.

### SUBSCRIPTION RATE FOR DUES-EXEMPT MEMBERS

Noting the Bylaws provision permitting The Council to set a subscription rate for Michigan Medicine to dues-exempt members, and also noting the financial loss being incurred annually by Michigan Medicine, The Council approved offering Michigan Medicine to dues-exempt members at $6 per year, effective March 1, 1965.

### LIFE MEMBERSHIP

The Council clarified the matter of life membership in MSMS as it might relate to life membership in a component medical society. MSMS Legal Counsel reported that it is clearly stated in the MSMS Bylaws that life membership in MSMS and life membership in a component medical society are entirely separate and the details with respect thereto are at the discretion of each.

### MSMS CONFERENCE ON MEDICAL WRITING

The Council authorized sponsorship of a Conference on Medical Writing for the Mass Media by the MSMS Publication Committee and the MSMS Public Relations Committee to be held at Kellogg Center, East Lansing, April 21, 1965.

### DEFINITION OF DEPENDENT NURSING SERVICES

The Council approved a statement defining dependent nursing services as proposed by the MSMS Committee on Nursing. This item will be published in Michigan Medicine.

### VETERANS HOME TOWN CARE FEE SCHEDULE

The Council approved recommendation to the Veterans Administration in Washington that the Michigan Relative Value Scale be adopted with a $5.00 conversion factor for a fee schedule which, if accepted, may be effective in the 1966 budget year.

### REVISED FEE SCHEDULE FOR WELFARE AGENCIES

Approval was given to a committee recommendation that The Council adopt a revised Uniform Fee Schedule, based on the Michigan Relative Value Scale, with a monetary factor of $5.00 applying to all sections.

### APPROVAL OF BICILLIN PROGRAM

The Council approved a committee recommendation that all possible steps be taken to continue the current program of bicillin for the prevention of rheumatic fever and heart disease.

### APPROVAL OF DIABETES DETECTION AGREEMENT

Upon recommendation of the Diabetes Control Committee, The Council approved the revised Diabetes Detection Program Agreement and authorized the MSMS President to sign this document.

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## Mediscene

**February 19**—Women's Auxiliary to MSMS, Whittier Hotel, Detroit.

**February 22-25**—Canadian-American Medical & Dental Ski Association, Boyne Highland, Harbor Beach.

**February 27**—Michigan Heart Day, Statler-Hilton Hotel, Detroit.

**March 3**—Michigan State Medical Society Council—Headquarters, East Lansing.

**March 11-12**—MSMS Maternal & Perinatal Conference, Pick-Durant Hotel, Flint.

**March 14-20**—National Poison Prevention Week.

**March 26-27**—Michigan Association of the Professions, Pantlind Hotel, Grand Rapids.

**April 14**—Michigan State Medical Society Council—Headquarters, East Lansing.

**April 25**—Michigan State Medical Assistants Society Seminar, Ann Arbor.

**May 18**—Dedication of WSU Medical Research Building.

**May 19**—Wayne State Medical Alumni Clinic Day and Alumni Reunion, Sheraton-Cadillac Hotel, Detroit.

**June 3**—Michigan State Medical Society Council, Headquarters, East Lansing.

**June 10**—Michigan Orthopaedic Society, Summer Meeting, Hidden Valley, Gaylord.

**By CLYDE T. HARDWICK**
**MSMS Economic Consultant**

# Economic Freedom and American Capitalism

Ours is the age of social consciousness. The collective body of Americans are worried, concerned, and feel responsible for youth, unemployed, and aged.

Also, our times are facing the challenge of losing liberty, freedom and individuality. Seldom do we disagree as to goals: the issue directly concerns means.

Thus, all Americans are concerned and worried about the health of the aged—even the economist. Let us remember the economic implications of a federally sponsored medicare or compulsory insurance program for the aged.

What happens to freedom and liberty of individuals when government takes over?

## *Issues of Our Times*

Americans have nothing to lose but their freedom when they ask more and more from government. We cherish our freedom to think, to speak, to write, to assemble, to associate, to work, to rest, to study, and to live with dignity. A free society expects and demands freedom of choice by consumers via the market place. We should be insulted with **compulsory** eating, **compulsory** dancing, **compulsory** housing, **compulsory** work, or **compulsory** hobbies or recreation, or **compulsory** health.

As soon as government invades the socio-economic fields of labor, agriculture, or management, somebody—if not everybody—loses some freedom. Ask the railroads what has happened since 1887 when government controls began. Freedom to plan, operate and manage railroads has long been trampled on and independent management has been severely limited. Isn't it interesting that the recent congress was fighting to get government to take over some medical services and at the same time suggesting relaxing of government interference with the troubled railroads?

This is the threat to the national freedom—that is, government assistance means control, which means the lessening of freedom in planning and choosing health services as individuals and groups!

## *Evolution versus Revolution*

All economists believe in constructive change or progress but some of us prefer gradual change or evolutionary progress which protects the best of the old and replaces only the weak pieces. Thus, we admit, some change in medical insurance and medical care must be sought—but transference of health care from the private sector to the public sector, for even the aged, should be fought on the principle of preserving freedom. Thus we may sometimes agree with revolutionizing content and goals—that is, better health for everybody, especially the aged, but the means and ways must remain private, not only individual but voluntary collective action, such as Blue Cross and Blue Shield.

We are against undue public intervention or unnecessary public takeover of historical private affairs.

We believe an individual may be weak or even feel as if lost, living or working alone, but voluntarily joining with other free individuals into a private association enables him to retain freedom without government domination; this is important to us to call on man's cooperative nature first before surrendering to government coercion.

Yes, we believe in economic planning but it must first take place within the framework of private enterprise and only in desperation will free men turn to government; e.g., in National Defense, but not in economic aspects of health care.

Why do we assume that men are incompetent as individuals or weak and unsuccessful when asso-

SOCIO-ECONOMIC

ciated voluntarily but when the same individual or groups become government agents or administrators they grow up to be "giants" or "geniuses."?

If man is not smart enough to work out a private system of caring for the aged, then there seems to be little hope for the same or similar men to solve the same problem with the same amount of resources just by transferring the organizational structure from private hands to public hands. If money is all that is needed, let the Federal government subsidize private insurance plans for the aged subscriber. This type system works well in Australia where government funds are directed through the private economy instead of replacing it with a government plan.

In keeping with our proposition of preserving freedom, Americans should have the free choice of the ways and means of maintaining health. This presentation is predicated upon that belief. Moreover, it is simply contended, that in the long run preference for the freedom of the market place instead of casting political votes in favor of curbing our freedoms is most desirable.

In other words, health via the ballot box is no assurance that economic laws will be suspended but rather that health costs will be obscured with mixing them with national defense and other government services. Therefore, this presentation has aimed to point out the economic burdens of health and the suggestion that there are two ways of handling it—leave health to the private sector as well as giving health over to government.

## *Internal Threats to the American Way*

Consequently, we face two threats to our American way of life. Externally, the revolutionary communists promise to bury us with collective forces. In addition, the internal group of men with good intentions are trying to reform our individualistic society with abandonment of personal freedoms in favor of a domestic collective system. At present, the latter group are the particular concern of the economic conservative. Of course, we want to mobilize our forces to fight communism but at the same time we do not want to destroy our values that distinguish us as Americans.

One way to defend ourselves from internal revolution is to review and re-establish our fundamental beliefs, goals and principles of the American way of life against which we carefully check all proposals for change. This means we must reaffirm our fundamental guidelines in the political, socioeconomic and professional areas of thought before subscribing to proposed "goody" practices.

Men of goodwill know and fully realize that the dynamic changes in the twentieth century cannot be solved with eighteenth century answers. Economic conservatives are for progress based upon wisdom and evolutionary changes in keeping with our heritage of individual freedom and responsibility. These eternal values we will fight for and struggle against internal as well as external enemies—anything less would be unbecoming to real Americans.

The aim of socialized programs, or government enforced programs of health, is to compel *equality of consumption* or a leveling of consumption. *To socialize is to equalize.* This is contrary to to an open, free society.

## *Conclusions*

Arguing for freedom and private medicine entails certain obligations and risks. Freedom from control means responsibility for individual performance. Outside controls come when responsibilities are shirked or abused. Furthermore, freedom to think and to act means the assumption of risks. Freedom-loving people invite the risk of failure and risk of hardships.

If we want security, then freedom may have to be exchanged therefore. Merchants selling in the free market place invite the troubles of selling, servicing and collecting prices of the products. In a similar fashion, professional personnel invite similar risks of the free market place.

If we want the freedom to serve, we must accept responsibility and risks of servicing and collecting from the clients. Thus, the professional has to avoid dependence on third parties or outside financing. The free market place has to shoulder the risks of its freedom to treat and deal directly with the clients. To defend freedom, the assumption of risks seems to be a small enough price to pay.

The key words are free choice, risk, competition, reward versus penalties, self-determination and responsibility.

Let's continue to march along the road of freedom with determination and courage!

## Hospital Labor Costs Jump

Hospital labor costs have jumped 545 per cent since World War II, according to the American Hospital Association. The AHA also maintains that 241 employees were needed to care for each 100 patients last year. In 1946, the ratio was 148 to 100.

## Beg Your Pardon

An article in the January issue of Michigan Medicine incorrectly identified the A.H.C.P. of Michigan company as the American Hospital Credit Plan; whereas the organization is the American Health Credit Plan. A.H.C.P. of Michigan, an advertiser in Michigan Medicine, offers Michigan residents a credit card system of payment for health expenses. A.H.C.P. of Michigan, Inc., is a franchise of American Health Credit Plan, the National Company conceived by several Battle Creek businessmen.

## *Welcome Rhode Island!*

As a member of the State Medical Journal Advertising Bureau, *Michigan Medicine* wishes to cordially welcome the *Rhode Island Medical Journal* into the Bureau. Rhode Island becomes the 35th participating state journal.

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# Outlook Bright Through '75 for Health Vocations

**By RICHARD M. CAMPAU**
**Research Director**

The employment outlook for persons interested in the health service occupations in the United States should be exceedingly bright at least through 1975, according to the Health Insurance Institute.

The Institute, reporting on its analysis of data from the U. S. Departments of Labor, and Health, Education and Welfare, said that in the next decade or more, young people can be virtually certain their services will be in demand if they enter occupations in the health services field.

The health service jobs include those for physicians, dentists, professional nurses, dental hygienists, dental laboratory technicians, dietitians, hospital administrators, medical record librarians, medical technologists, medical x-ray technicians, occupational therapists, optometrists, osteopathic physicians, pharmacists, physical therapists, podiatrists, and others.

* * *

IN ADDITION TO THE growing U. S. population, the Department of Labor lists several primary factors which will effect the availability of health care jobs. Among these factors are the country's expanding and aging population; the rising health consciousness of the general public; the extension of hospitalization and medical insurance plans; the rapid expansion of expenditures for medical research; and the continued provision of health care for veterans, and servicemen and their families.

The U. S. Surgeon General has set a goal of 680,400 active professional nurses by 1970, or over 120,000 more nurses than were active in 1963. But the employment outlook is even better than the Surgeon General's goal would indicate. The reason is the nursing profession is made up almost exclusively of women, thousands of whom leave the profession each year to assume family responsibilities. These nurses, plus those who retire or die each year, are expected to average 25,000 a year between now and 1970, and must be replaced. Another 15,000 nurses a year (average) must be added to meet the public need.

* * *

ACCORDING TO government statistics, the medical profession numbered 289,200 physicians in 1963 (including osteopaths, retired physicians, doctors who serve as instructors, and other non-practicing physicians) and provided the public with a ratio of 149 physicians per 100,000 civilian population.

With 92 medical schools now planning expansion of facilities, and with 12 to 15 new medical schools expected in this decade and part of the next, the doctor-public ratio is expected to rise to 153 doctors per 100,000 civilians in 1970, and to 154 doctors by 1975.

However, with more and more physicians moving out of private practice and into medical research, government work, or into work in underdeveloped countries (as over 2,000 American doctors are doing today in Latin America, Asia, and Africa), the demand for more physicians serving the public will be that much greater in years to come, the government report stated.

* * *

THE FIELD OF dentistry today appears to offer young people an excellent opportunity for their life's work. Department of Health, Education and Welfare figures indicate that the ratio of dentists per 100,000 civilians has dropped consistently since 1950 when there were 57.2 dentists per 100,000 civilians. In 1963, the ratio dropped to 55.7, and at the present rate of dental students and graduates, the ratio is expected to diminish to 54.5 in 1970, and then to 53.5 dentists per 100,000 population by 1975.

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For further information and application form, write: William B. Terhune, M.D., Medical Director, The Silver Hill Foundation, Box 1177, New Canaan, Connecticut.

## *Professional Week Planned; Set MAP Congress, March 26-27*

"Professional Week 1965" will be proclaimed for March 21-27, to concur with the Sixth Annual Congress of the Professions. The Congress of the Michigan Association of the Professions will be held in the Pantlind Hotel, Grand Rapids, March 26-27.

Special emphasis will be given at the MAP Congress on the role played by ancillary and auxiliary groups in the practice of any profession. Top representatives of the ancillary associations are being invited to attend.

The Congress is something in the manner of a "three-ring educational circus." One portion of it will explore relationships between the professions and such forces as business, industry, government, labor, suppliers, assistants, associates, etc. A second portion will deal with the growing complexities of relationships between professions in the U.S. with professional people abroad.

A third part of the program will explore in depth how professional people can use their talents to better serve the needs of the people and also how those services can be presented more attractively and be ethically promoted.

"There is no good reason why people with substandard qualifications should be successfully impinging upon professional practices," said Henry L. Homan, D.D.S., of Grand Rapids, President of MAP. "This is especially true if professional people ethically 'merchandise' their services."

J. Russell Brink, M.D., of Grand Rapids, President of the Kent County Medical Society, is the member of the Congress Planning Committee representing the medical profession.

Miss Cecile Rutan, of Hanover, received the coveted "Medical Assistant of 1964 Award" during the Michigan State Medical Assistants' Society annual convention. The award was made by Tom Young, Battle Creek, for the Medical-Dental-Hospital Bureaus of Michigan.

# ANCILLARY SECTION

### Sets 1965 Annual Meeting

The annual summer meeting of the Michigan Orthopaedic Society has been set for June 10-11-12, 1965 at the Hidden Valley, Gaylord.

Details may be obtained from the MOS secretary, R. W. Pomeroy, M.D., 1322 E. Michigan Ave., Suite 102, Lansing.

## WSU Alumni Event Set for May 19

Final arrangements are being completed for the 1965 Wayne State Medical Alumni Association Clinic Day and Alumni Reunion, to be held May 19.

The event will be held at the Sheraton-Cadillac Hotel, with registration to begin at 8:30 a. m. Professional sessions will be offered throughout the day with a dinner-dance at 7 p. m.

Special honorees this year will be the members of the "Class of 1915."

## *Materials about Cancer Offered to Teachers*

The initial response to a Michigan Cancer Coordinating Committee educational effort with Michigan high schools has surpassed expectations.

Early in January, a letter and kit of available materials was sent by MCCC to 1198 principals of high schools and junior high schools. One free copy of a teaching manual, "Teaching About Cancer," and a student booklet, "Youth Looks at Cancer," were sent to each principal. Additional copies are being made available at cost to the schools.

The materials are offered "to help science teachers instruct their students on the subject of cancer."

# Family Planning Policy by State Printed in Full

(The following is the text of the Michigan Department of Health policy of Family Planning. This policy statement was sent out with the Bi-weekly Circular to local health departments on January 9, 1965.)

"The Michigan Department of Health strongly supports the concept of family planning and, in recognition of the importance of family life education to effective family planning, encourages the development of family life education programs as well as premarital and marital counseling by qualified individuals and organizations.

"Family planning, as seen by the Michigan Department of Health, is a comprehensive plan of action by which individual families attempt to develop their full potential for physical, mental, and social well-being in the interest of better public and personal health.

"As advocated by the Department, family planning is based on all the knowledge and understanding derived from an individual's experience as a family member, augmented by the related educational experiences which may be provided by physicians, health agencies, churches, schools and other community organizations.

"The health implications of family planning, as defined by the Department, consist of making information and medical assistance available to those who would like to have a child, as well as to those who would like to postpone this event, in a manner consistent with their desires and beliefs.

"From a health standpoint, family planning in relation to family size has major program implications. Wanted children are essential to total family health—unwanted children frequently have an adverse effect. When family size exceeds family means, adequate housing, food, clothing and other items essential to family health are often denied family members. Unplanned pregnancies often cause a woman to seek illegal abortion with subsequent devastating effect on individual and family life and health.

"Recognizing the importance of family size to family health, the Michigan Department of Health encourages individuals to seek medical assistance with problems relating to the conception of planned and wanted children. Such assistance should be provided only by physicians, or through programs conducted with the support of physicians, and should always preserve the individual's freedom of decision with regard to the means that the desired end is accomplished.

"While the Department believes that family planning is good for health at any point in family life, it is desirable that it begin at the time of premarital counseling and continue throughout the childbearing years so as to prevent health problems and to help in the fulfillment of family desires.

"It is the Department's position that assistance in family planning should be made available to all who wish it in accordance with their individual desires and beliefs, and that payment for these services for the indigent and the medically indigent is a proper and reasonable use of public funds."

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# List Postgraduate Courses Offered by U-M

The following courses are being offered by the Department of Postgraduate Medicine. Specific details about each course are available upon request to the Department of Postgraduate Medicine, University Hospital, Ann Arbor, Michigan.

### Continuous Courses

Allergy, March 22-24
Dermatology, April 28-30
Diseases of the Heart, March 8-12
Electrocardiographic Diagnosis, February 15-19
Endocrinology & Metabolism, April 19-23
Interfertility & Endocrinology, March 4-5
Neurology, Clinical, March 1-2
Nuclear Medicine, February 1-3
Obstetric & Gynecologic Anatomy, April 12-23
Obstetric & Gynecologic Pathology, March 29-April 9
Ophthalmology Conference, April 19-21
Otorhinolaryngology Conference, April 15-17
Psychiatry, February 22-24
Pulmonary Diseases, April 5-7
Radiology, Diagnostic, April 12-14
Renal Disease, Hypertension and Vascular Disease, February 8-12
Rheumatology, March 29-April 2
Surgical Anatomy, April 5-May 14
Therapeutics, Recent Advances in, May 3-7

### Intermittent Courses

Psychiatry for Pediatricians, (Wednesday afternoons), February 17-May 5

Note: Several additional courses began in January.

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# Horn Leads Pathologists; McDonald Chosen for '66

Robert C. Horn, Jr., M.D., Detroit, is directing the Michigan Society of Pathologists as president this year, and John R. McDonald, M.D., Detroit, is carrying out the duties assigned the president-elect.

Others chosen at the recent annual meeting were Harold E. Bowman, M.D., Grand Rapids, secretary-treasurer; Rosser L. Mainwaring, M.D., Dearborn, and James G. Wolter, M.D., Detroit, both Council members, and Doctor Bowman, as Councilman to ASCP.

# Heart Scientific Session, Feb. 26, 27

As in the past, physicians will primarily be interested in the Saturday portion of the Michigan Heart Association "Annual Heart Days" in Detroit—set this year for February 26 and 27. A fine all-day medical scientific session with four out-of-state speakers will be held Saturday at the Statler Hilton Hotel.

Other special features are being added this year, including (1) A Cardiovascular-HBP Symposium for nurses, February 26. (2) A discussion on the "Place of the Cardiac in Industry and at Home," February 26. (3) All-day class in closed chest cardiac resuscitation. (4) A free public forum co-sponsored by the Detroit Free Press, February 26, on "The Preventables—Rheumatic and Hypertensive Heart Diseases."

The medical program Saturday morning will offer at 9:30 a.m., "Rheumatic Fever: Recent Advances in Diagnosis, Treatment and Prevention" by Gene H. Stollerman, M.D., Memphis; 10:30 a.m., "The Diagnosis of Congenital Heart Disease in the Infant" by Robert Miller, M.D., Chicago; and at 11:00 a.m., a panel about "Heart Disease in Children: Identification and Management," with Aaron M. Stern, M.D., Ann Arbor, as moderator. The panelists will be Edward W. Green, M.D., Detroit; Manes S. Hecht, M.D., Detroit; Doctor Miller and Doctor Stollerman.

The afternoon program lists at 2:30 p.m., "Reversible Uremia" by George Schreiner, M.D., Washington, D. C.; 3:30 p.m., "Cerebrovascular Lesions Causing Stroke; Identification and Surgical Treatment" by C. G. Rob, M.D., Rochester, New York; and at 4:00 p.m., a panel on "Acute Stroke: Diagnosis and Management," with Sibley W. Hoobler, M.D., Ann Arbor, as moderator. The panelists will be Harriet Dustan, M.D., Cleveland; John S. Meyer, M.D., Detroit; Doctor Rob and Docter Schreiner.

The Friday panel on the status of the cardiac at home and in industry, from 2 to 5 p.m., will include Howard B. Sprague, retired from Harvard University; Neill K. Weaver, Humble Oil Co.; George E. Burch, New Orleans; and Irving Bluestone, Detroit, assistant to Walter Reuther.

The nursing symposium Friday will hear John M. Shuey, M.D., Detroit; A. C. Corcoran, M.D., Ann Arbor; Doctor Hoobler, Doctor Dustan, and others.

Speakers at the public forum in the Cobo Hall Grand Ballroom, 8:15 p.m. Friday, are John Keyes, M.D., Detroit, and Doctors Stollerman, Dustan, and Meyer. Moderator will be Park W. Willis III, M.D., Ann Arbor, president of the Michigan Heart Association.

## WJBK-TV Cameras Help Tell Smoking and Health Story

The work of the Michigan Council on Smoking and Health was described to metropolitan residents over the MAP "Decisions" television feature, January 9 on WJBK-TV, Channel 2, Detroit. One of the participants was Henry J. VandenBerg, Jr., M.D., Detroit, Chairman of the new Michigan Council on Smoking and Health, and also Chairman of the MSMS Cancer Control Committee. Hugh W. Brenneman continues as the moderator of this weekly Saturday afternoon program.

## WSU Obstetrics Day Speakers Named, March 24

The program has been completed for the Seventh Annual "Resident's Day in Obstetrics and Gynecology" at Wayne State University, March 24, at the Wayne County Medical Society.

A highlight will be the Milton A. Darling Memorial Lecture at 7:30 p.m. by Donald G. McKay, M.D., of Columbia University, New York City, on malfunctioning ovaries.

The morning program will begin at 9 a.m. and the afternoon session will extend from 1:45 to 4:30.

The morning program will offer "Rectal Versus Sterile Vaginal Examinations in Late Pregnancy and During Labor," by John P. Ottaway, M.D., Grosse Pointe Farms; "The Clinical Significance of the Pathology of Toxemia of Pregnancy," by Donald G. McKay, M.D.; "The Response of Infertile Women to Endocrine Therapy," by Charles S. Stevenson, M.D., Detroit; "The Response of Infertile Men to Endocrine Therapy," by Robert B. Leach, M.D., Detroit; and a panel on "The Endometrium, Ovary and Testis in Infertile Individuals," with moderator, Doctor Mack, and panelists, Doctors McKay, Leach and Stevenson.

The afternoon session will present "Sperm Migration in Women: Recent New Concepts," by Kamram Moghissi, M.D., Detroit; "Community Obstetrics and Gynecology," by Herman A. Ziel, Jr., M.D.; "What Constitutes Good Gynecological Hospital Practice Today?" by William W. Jack, M.D., Grand Rapids; and a panel on "The Prevention of Maternal Death from Hemmorrhage," with moderator, Charles P. Hodgkinson, M.D., Detroit, and panelists, Tommy N. Evans, M.D., Ann Arbor; Charles E. Darling, M.D., Detroit, and R. Ralph Margulis, M.D., Birmingham.

## 37 Michigan Hospitals Serve Mental Patients

Statistics recently available from the U. S. Public Health Service reveal that 37 hospitals in Michigan discharged a total of 18,648 psychiatric patients during 1963.

# 8 Steps In Final Assault On Tuberculosis

**By JOHN ISBISTER, M.D.**
**Tuberculosis Control Office**
**Michigan Department of Health**

A little more than ten years ago, there were 4,700 tuberculosis patients hospitalized in Michigan sanatoriums. Next year, we estimate there will be approximately 1,700 such patients.

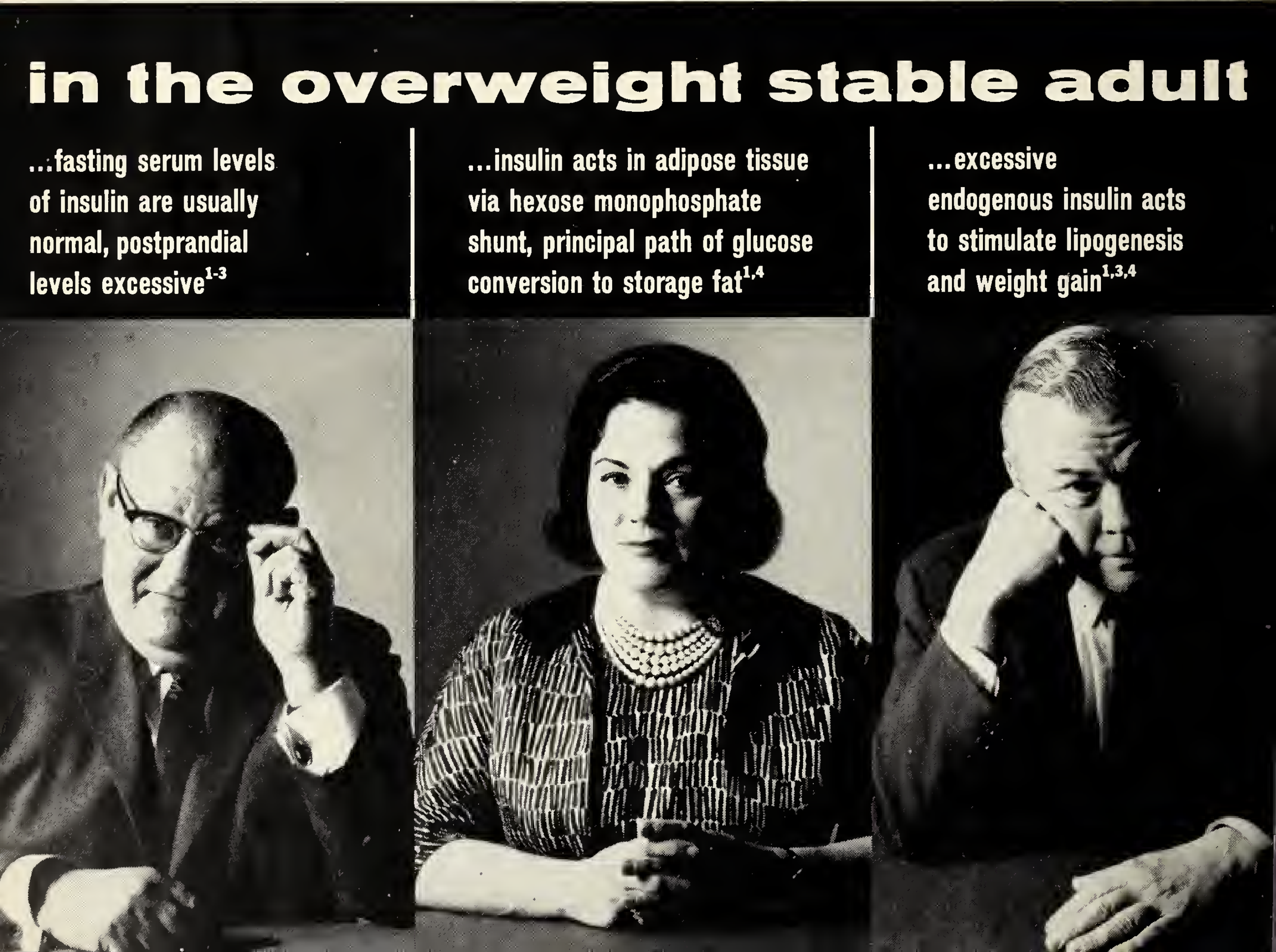
This represents a reduction of about 64 per cent and reflects the tremendous strides taken in tuberculosis control and treatment. But the cost of tuberculosis hospitalization over these same years presents a different perspective. In 1952, with 4,700 patients, the tax-dollar-cost approached $17,000,000. The estimated cost for the hospital treatment of 1,700 patients in 1965 approaches $12,000,000.

While the caseload has been reduced by almost two-thirds, the cost of hospitalization has been reduced by only about one-third.

This, in brief, summarizes the tuberculosis problem today. We have skimmed off the cream, so to speak, and now the rate of decline in incidence is leveling off. We are like a man trying to walk down an ascending escalator. If we continue to move at about the speed of the escalator, we will remain where we are and never reach the bottom. If we hope to reach the bottom, we must accelerate our rate of progress. Unfortunately, an attitude of complacency among the general public as well as the medical profession, tends to prevent such acceleration.

The fact is that the medical profession, by and large, has lost interest in tuberculosis. Younger physicians suggest that tuberculosis is no longer a medical problem and that knowledge of the epidemiology, diagnosis, and treatment of the disease need no longer be of serious concern to the practicing physician. Medical graduates interested in work in tuberculosis hospitals are extremely difficult to find an adequacy of pay does not seem to be a major problem. It is even difficult to get a program on tuberculosis accepted as the subject of a scientific meeting in local medical societies.

In the face of this situation, the Surgeon General of the United States was directed by Congress to convene a task force on tuberculosis to study the


in the overweight stable adult

...fasting serum levels of insulin are usually normal, postprandial levels excessive[1-3]

...insulin acts in adipose tissue via hexose monophosphate shunt, principal path of glucose conversion to storage fat[1,4]

...excessive endogenous insulin acts to stimulate lipogenesis and weight gain[1,3,4]

problem and to make recommendations for improvement in the control program. Its report was delivered to the Surgeon General last December. In essence, that report called for a more diligent application of our present knowledge and techniques in the standard approach to communicable disease control: casefinding, case treatment, and case follow-up.

Here in Michigan, we suggest the following considerations:

1. Shift emphasis from mass screening programs to techniques that will identify persons at risk and provide for their repeated examination.
2. Develop clinic or out-patient care facilities to provide continuing treatment, integrating treatment with hospital medical care.
3. Intensify detection efforts among contacts of known cases.
4. Tuberculin test ALL school children upon entry and at the age of fourteen years.
5. Examine ALL school teachers and other school employees for tuberculosis annually.
6. Administer drugs to all contacts of newly diagnosed cases of tuberculosis, or, if this is impractical (as in slum areas or among migrant workers), administer BCG vaccine to non-reactors (those found by skin test to be free of infection).
7. Administer anti-tuberculosis drugs to ALL unhospitalized patients with active disease.
8. Keep ALL discharged patients, who have become inactive, on drug therapy for at least two years, then follow up for three more years with semi-annual examinations.

The role of the private practitioner is, perhaps, more important now than ever before in terms of the continuation of drug therapy months after a patient has been discharged from a sanatorium. Only by working together can public health and private medicine begin what will hopefully be the final assault upon an ancient enemy. Ultimately, the degree of success we achieve will depend on how much we are willing to put into the effort.

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## Neuropsychiatric Group Elects

Calvin H. Chen, M.D., Northville, recently was chosen President-Elect of the Michigan Association of Neuropsychiatric Hospital and Clinic Physicians.

President for 1965 is Sidney B. Jenkins, M.D., Eloise. The Secretary is Simon W. Maroko, M.D., Pontiac, and the delegates to the Michigan Mental Health Assembly are Doctor Jenkins and Jacob J. Miller, M.D., Northville.

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**1.** Gordon, E.S.: Metabolism 11:819, 1962. **2.** Grodsky, G.M. et al.: Metabolism 12:278, 1963. **3.** Weller, C. et al.: Scientific Exhibit, A.M.A., June 1962. **4.** Sadow, H.S.: Metabolism 12:333, 1963. **5.** Faludi, G.: J. Am. Med. Women's Assoc. 18:722, 1963. **6.** Faludi, G.: Geriatrics 18:452, 1963. **7.** Williams, R.H.: Textbook of Endocrinology, Ed. 3, Saunders, Phila., 1962, p. 610. **8.** Weller, C. and Linder, M.: Am. Therap. Soc., June 1963. **9.** Moss, J.M. et al.: Med. Times, July 1964.

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# Doctor Brennan Leads Cancer Coordinating Committee for 1965

Directing the work of the Michigan Cancer Coordinating Committee for the coming year will be Michael J. Brennan, M.D., Detroit, as Chairman. Continuing as Vice-Chairman is John A. Cowan, M.D., Lansing. Doctor Brennan succeeds Bernard E. Luck, D.D.S., Lansing, who had been Chairman for the past several years.

Warren F. Tryloff, Associate Director of MSMS, continues to serve as Secretary-Treasurer.

The MCCC is comprised of the Michigan State Medical Society; Michigan Department of Health; Michigan Health Officers Association; Michigan State Dental Association; American Cancer Society, Michigan Division; American Cancer Society, Southeastern Michigan Division and Michigan Cancer Foundation.

### Approve Joint Staff

The Gratiot Community Hospital Medical Staff has approved changes in its bylaws which permit osteopathic physicians to have staff privileges.

## League for Nursing Issues Career Folder, Directory

Up-to-date information describing opportunities and education in the field of nursing has just been released to principals of all junior and senior high schools in Michigan. Two brochures, **"Guide for Counselors—Nursing As A Career"** and a **"Directory of State Approved Schools of Nursing in Michigan,"** were distributed recently by the Michigan League for Nursing. This project is financed by the League's membership, the Michigan United Fund and subscriptions from schools of nursing. Content of the Counselor's Guide follows suggestions from counselors who are members of the League.

Students and parents may obtain a single copy of the directory from the Michigan League for Nursing, Room 216, 51 West Warren Avenue, Detroit, Michigan 48201.

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# IN MEMORIAM

## KARL G. PINCKARD, M.D.

Karl G. Pinckard, M.D., 69, Dearborn, died unexpectedly at Albany, New York, on December 2, 1964.

Born in Kansas City, Kansas, Doctor Pinckard practiced medicine in Dearborn since 1924, until his retirement three years ago.

Doctor Pinckard was graduated from Northwestern University School of Medicine and interned at Harper Hospital, Detroit. He was a staff member of Harper, Woman's and Oakwood hospitals.

Doctor Pinckard was a Life Member of the Michigan State Medical Society.

## CHARLES L. RIVARD, M.D.

Charles L. Rivard, M.D., 63, St. Clair Shores physician, died January 1, 1965, in Petoskey, Michigan.

Born in Grosse Pointe, Doctor Rivard received his medical degree from the St. Louis, Missouri, College of Medicine. He served his internship at Providence Hospital, Detroit.

Dr. Rivard was twice elected Macomb County coroner, and was a former chief of staff at St. Joseph Hospital. At the time of his death he was on the staffs of St. Joseph and St. John hospitals.

In World War II he was a major in the U. S. Army medical corps and served four years, during which time he participated in the Africa, Italy and Sicily campaigns.

## PAUL G. SCHRIER, M.D.

Paul G. Schrier, M.D., 64, retired Kalamazoo physician, died January 1, 1965, at his home.

A native and lifelong resident of Kalamazoo, Doctor Schrier was graduated from the University of Michigan School of Medicine in 1926. He served his internship at St. Mary's Hospital in Grand Rapids.

Doctor Schrier served on the staffs at Borgess and Bronson Hospitals, and was a former Chief of staff at Bronson.

A veteran of World War II, Doctor Schrier was a medical officer in the Navy in the Pacific Theater.

Doctor Schrier was a retired member of the Michigan State Medical Society.

## GELMER A. VAN NOORD, M.D.

Gelmer A. VanNoord, M.D., 56, Grand Rapids physician, died December 21, 1964.

A life-long resident of Grand Rapids, Doctor VanNoord obtained his medical degree from the University of Michigan School of Medicine. He served his residency at the Henry Ford Hospital in Detroit. He was on the staff of Blodgett Memorial Hospital, Grand Rapids, and for the last eight years was superintendent of Pine Rest Christian Hospital at Cutlerville, having been associated with that institution since 1939.

# COUNTY SOCIETIES

### *Begin Oakland Trust Fund*

In establishing a trust fund to promote health and welfare throughout Oakland County with the proceeds of the Oakland County Medical Society anti-polio drive, the Society has stressed that "the excess belongs to the citizens of the entire county and not in any way to the medical group." A trust fund board is being appointed, and will include two representatives of the medical society.

In Oakland County, the vaccine cost $200,000, while contributions totaled about $400,000—leaving a trust fund of $200,000.

### *Sanilac Gives Nursing Scholarship*

The Sanilac County Medical Society has awarded its nursing scholarship to Miss Karen Corp, of Carsonville. She is a student at the Hurley School of Nursing at Flint.

### *Organize Calhoun Foundation*

A Calhoun County Medical Society Foundation, Inc., has been established by the Calhoun County Medical Society upon the recommendation of the Calhoun County Polio Fund Citizens' Committee. The Foundation will begin by administering $40,211 which was the excess from the oral polio vaccine clinics. The Medical Society had appointed the Citizens' Committee, which recommended the Foundation to provide financial assistance to nursing trainees and postgraduate students, medical technicians, laboratory workers, medical instructors and teachers, and institutions offering courses in ancillary medical services.

### *Lapeer Aids County Hospital*

The surplus of the Lapeer county-wide oral polio vaccine clinics has been given by the Lapeer County Medical Society to the Lapeer County General Hospital. The project showed a net of $4,500.

### *Allegan Splits Polio Proceeds*

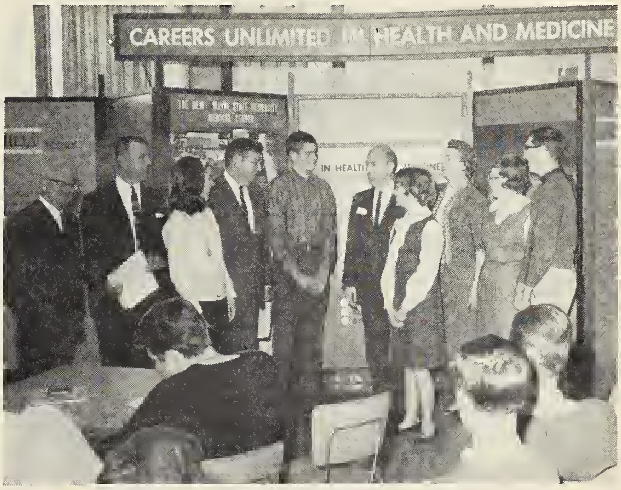
The Allegan County Medical Society, which discovered it had $15,710 left over from the oral polio vaccine clinics, contributed $1,200 for physical therapy equipment for the Allegan County Medical Care Facility and then divided the balance equally among the county's three general hospitals. The gifts were given to the three hospitals for capital improvements.

### Students at Birmingham Study Medical Careers

Several hundred students learned more about possible careers as doctors during the Seaholm High School Career Day, sponsored recently by the Birmingham Rotary Club. Through the cooperation of the Wayne State University School of Medicine, a fine exhibit was presented by MSMS.

Physicians reportedly assisted in the several sessions were Doctors Richard R. Galpin, Milton B. Stuecheli, Elvin Poznanski, James McHugh, Nanette Jagnow, Peter Barlow, L. Jerome Fink and William Cutler.

Ralph T. Wills, MSMS director of community relations, attended the Career Day along with John A. Doherty, executive director of the Michigan Health Council, who also used his exhibit about careers in rehabilitation.


CAREERS UNLIMITED IN HEALTH AND MEDICINE

Throughout the year and across the state, county medical society members provide excellent career counseling information to Michigan students. Richard R. Galpin, M.D., of Birmingham, fifth from right, directed a fine Oakland County Medical Society project recently at Birmingham Seaholm High School. MSMS, the Michigan Health Council and Wayne State University Medical Center cooperated with personnel, displays and career materials.

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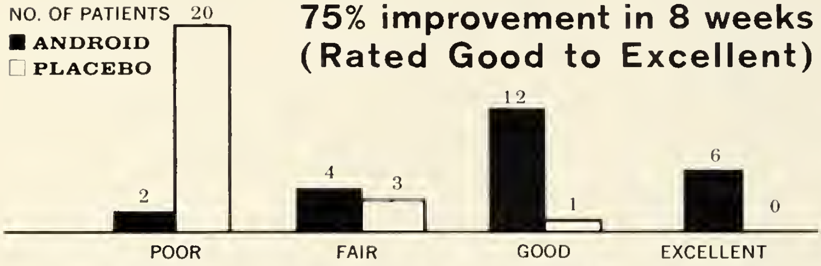

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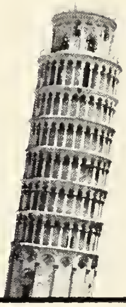
* 1. *Treatment of Impotence with a Methyltestosterone-Thyroid Compound (Android)*, M. H. Dubin, *Western Medicine*, 5:67 Feb. 1964.
2. *Methyltestosterone-Thyroid in Treating Impotence*, A. S. Titeff, *General Practice*, Vol. 25, No. 2, February, 1962, pp. 6-8.
3. *Thyroid-Androgen Relations*, L. Hellman, et al., *The Jrl. of Clin. Endocrinology and Metabolism*, August 1959.
4. Brochure Discussing Thyroid-Androgen Interrelationship.



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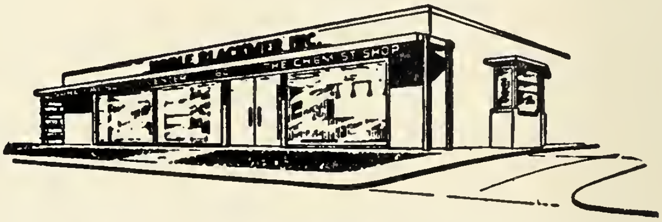

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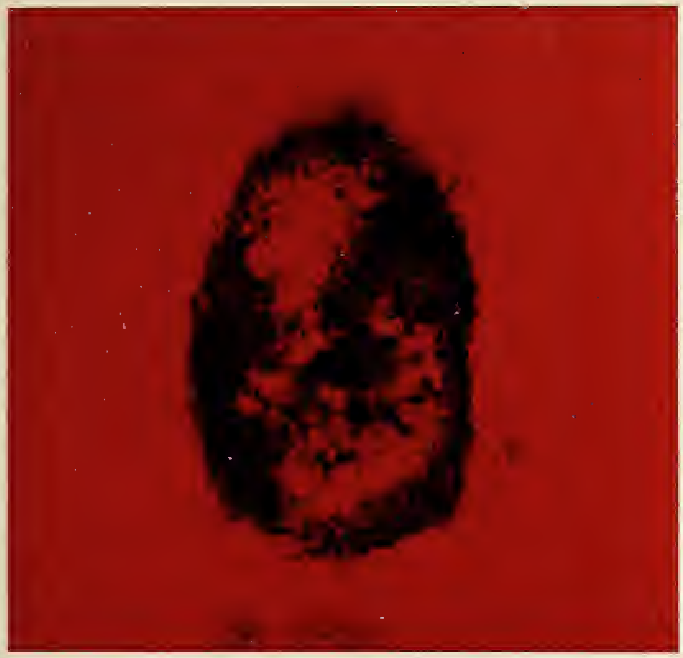
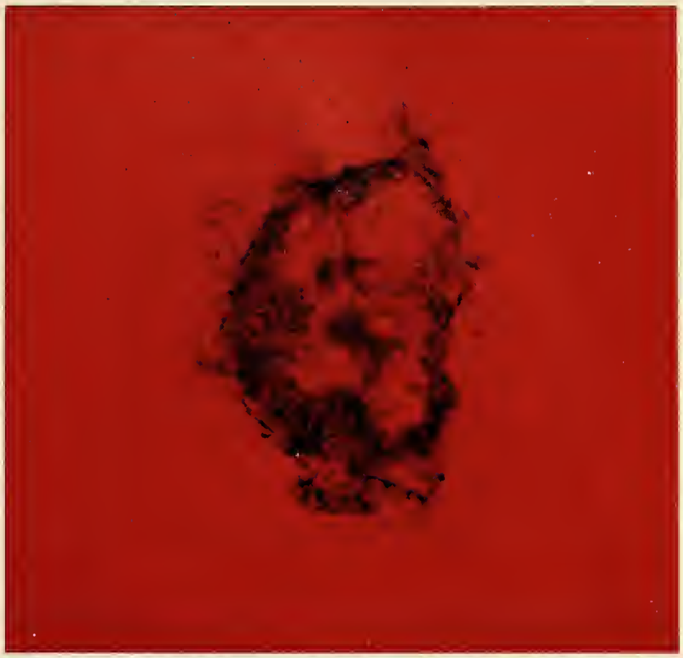


*Electron micrograph of normal* H. influenzae *organism.*



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*References:* 1. Millard, F. J. C., and Batten, J. C.: Brit. M. J. *i*:1159 (April 28) 1962. 2. Ivler, D., *et al.*: Abstracts, Third Interscience Conference on Antimicrobial Agents and Chemotherapy, October 1963, p. 32. 3. Stewart, G. T.: Pharmakotherapia *1*:197, 1963. (Progress in Drug Therapy). 4. Grant, I. W. B., *et al.*: Brit. M. J. *ii*:482 (Aug. 18) 1962. 5. Millard, F. J. C., and Batten, J. C.: Brit. M. J. *i*:644 (March 9) 1963. 6. Oswald, N. C.: Postgrad. Med. *35*:233 (March) 1964. 7. Howells, C. H. L., and Tyler, L. E.: Brit. J. Clin. Pract. *17*:321 (June) 1963. 8. May, J. R., and Delves, D. M.: Thorax *19*:298, 1964. 9. May, J. R., *et al.*: Lancet *ii*:444 (Aug. 29) 1964. 10. Pines, A.: Lancet *ii*:445 (Aug. 29) 1964.

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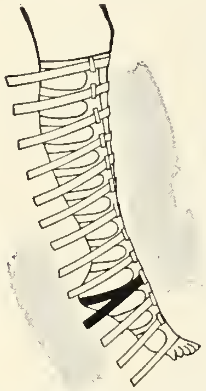

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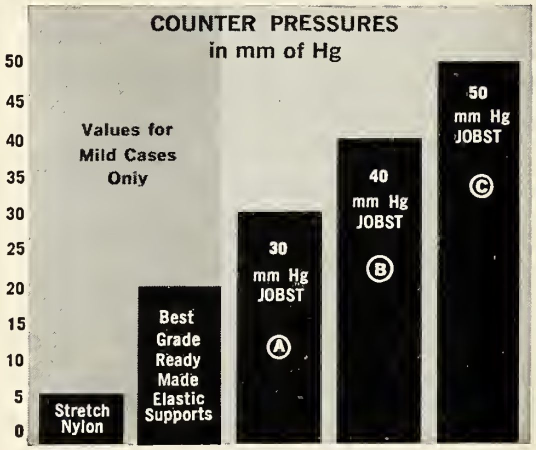

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L'Anse, Winkler Nursing Home
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Lansing, Fairview Convalescent Home
Lansing, Mapleshade Convalescent Home
Lansing, Newcomb Nursing Home
Lansing, Roselawn Convalescent Home
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Lincoln, Lincoln Haven Rest Home
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Ovid, Ovid Nursing Home
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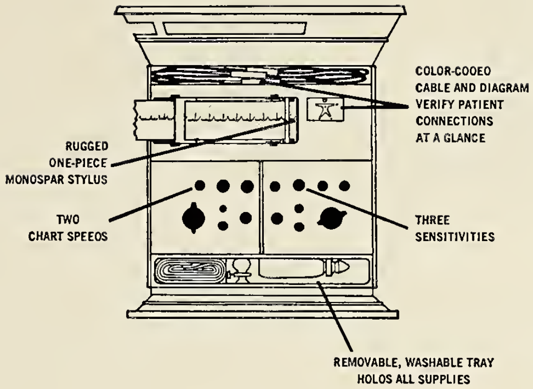
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# Reporting as Ordered

**A Monthly Commentary**
**By HUGH W. BRENNEMAN,**
**Executive Director**

It isn't easy to write for a medical journal.

If the topic is scientific some readers will sniff and say, "That isn't new. . . ."

If the content is socio-political-economic other readers may sniff, even louder, and say, "That isn't medicine. . . . ! ! ! ! !"

Consequently, with some trepidation, we have embarked upon this monthly stint of one page per issue. Its purpose is to offer Michigan Medicine readers information about what is being planned or promulgated at MSMS headquarters—who is doing it—and why. At least, that was the key instruction given by Doctor B. M. Harris' Publication Committee after it had determined that this effort be made.

## TWX

Communication is big and fast today. In tune with both the potential and need for increasing the speed and completeness of messages to and from the AMA and between the separate state medical societies, the AMA House of Delegates at its meeting in Miami Beach approved installation of "Teletypewriter Exchange Service" (TWX) equipment at the option of each state medical society.

**The AMA defrays the expense of installation in each headquarters and the training of personnel. The machines are rented by the AMA at a total cost of $20,000 annually. Cost of messages is borne by the sender. For example: if MSMS in East Lansing uses it to communicate with the AMA in Chicago, the cost would be $1.50 for a 900 word message.**

Also, the system permits MSMS to communicate with any other state society without going through the AMA. In fact, it will allow MSMS headquarters to send and receive messages with all the TWX subscribers in U. S. and Canada. The system operates 24 hours a day and is set to receive messages on a continuous basis with no operators.

## Plus Xerox, Multigraph, Mimeograph, etc.

During this past year the MSMS has speeded up its headquarters' communication facilities. We reduced our stenographic staff by two, added Maynard Hoover as a full-time production man, rented a Xerox machine, and obtained the use of MAP's multigraph.

**The result is much better, more economical and faster reproduction of all material, including the new MEDIGRAM. Also we get quicker copying and wider distribution of those intricately printed materials which often require but a few copies. All this at no additional cost compared with the previous system.**

## Plans and More Plans

Sometimes associations are accused of brainwashing their members. MSMS is more guilty of brainstorming its members. For weeks, a day-by-day, hour-by-hour plan for the 100th Anniversary of MSMS has been growing as various committees and groups dig, dig, dig at the details with dedicated devotion, striving to divine the desires of members living and dead.

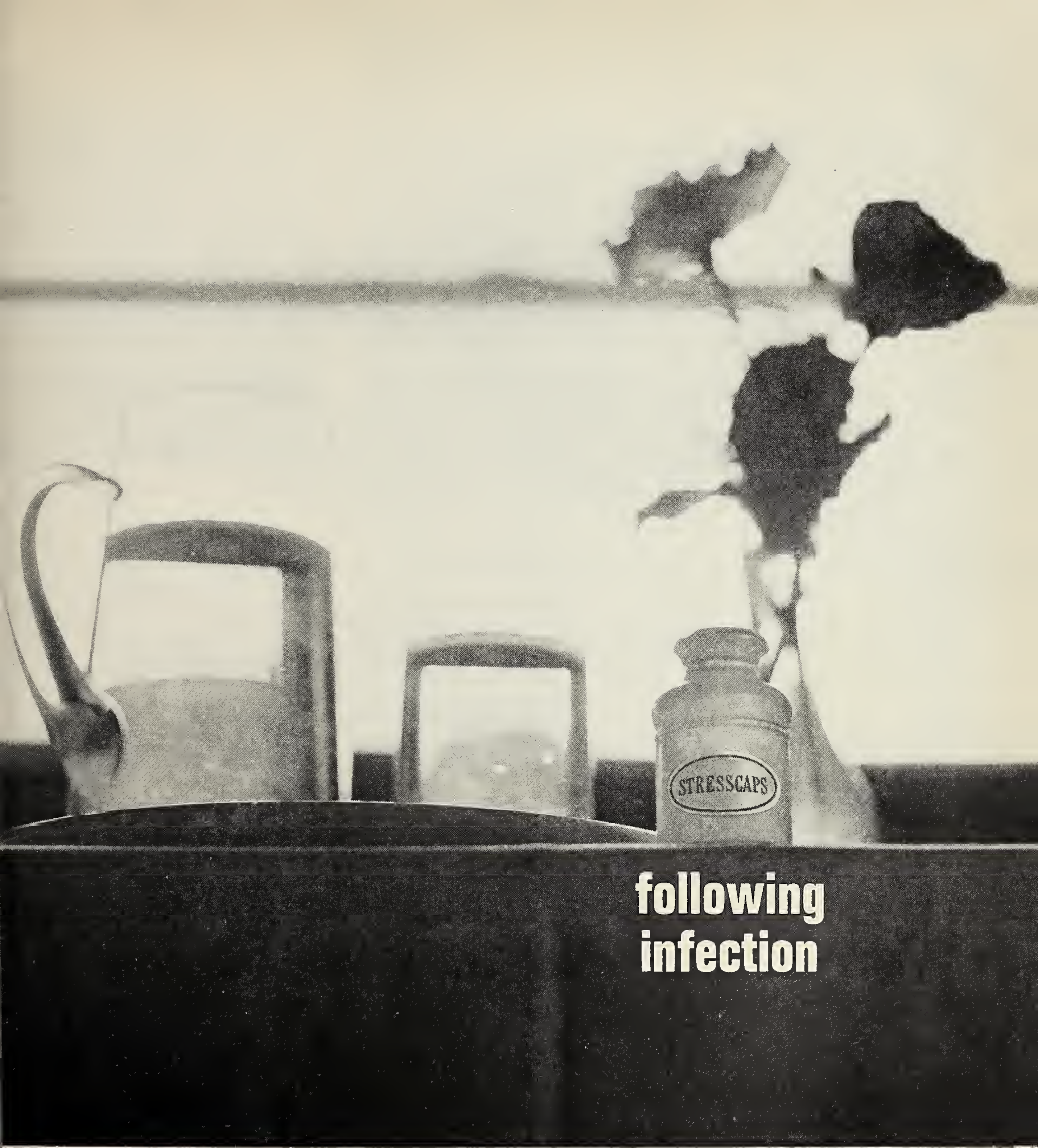
Of foremost importance is Doctor H. A. Towsley's Program Committee, which has been carefully erecting the structure of the scientific meeting "without which there is nothing."

The Sections are developing plans apace.

Also among these hard working groups is the Senior Staff of the MSMS headquarters office which consists of Helen Schulte, Bob Roney, Dick Campau, Ray Scott, Ralph Wills, Herb Auer, Mike Riley, Warren Tryloff and Hugh Brenneman. These people alone have spent a total of over 500 man-hours on the Centennial already!

Be assured no other state professional society in this or any other state has put a centennial show together that is comparable to the promise of this one. Any doctor that misses it will feel forevermore like a 4F at a war veterans' reunion.

Instructions on how to operate the "33 ASR Teletypewriter (TWX)" are given by a Bell Telephone service adviser, Audrey J. Cameron, center, to two MSMS employes, Maynard J. Hoover, production manager, and Julie Perdue, secretary.



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# MICHIGAN MEDICINE

## the journal of the michigan state medical society

March 1965 • Vol. 64 • No. 3

In this issue of Michigan Medicine, you'll find Advance Information about MSMS Medicine and Religion Day at Centennial Session ☐ Four exceptional Original Articles leading off with one about Brain Tumors ☐ A challenge from President McGillicuddy about AMA-ERF ☐ News and Editorial Comment about the MSMS Measles Campaign ☐ And a preview of MAP Congress of the Professions ☐

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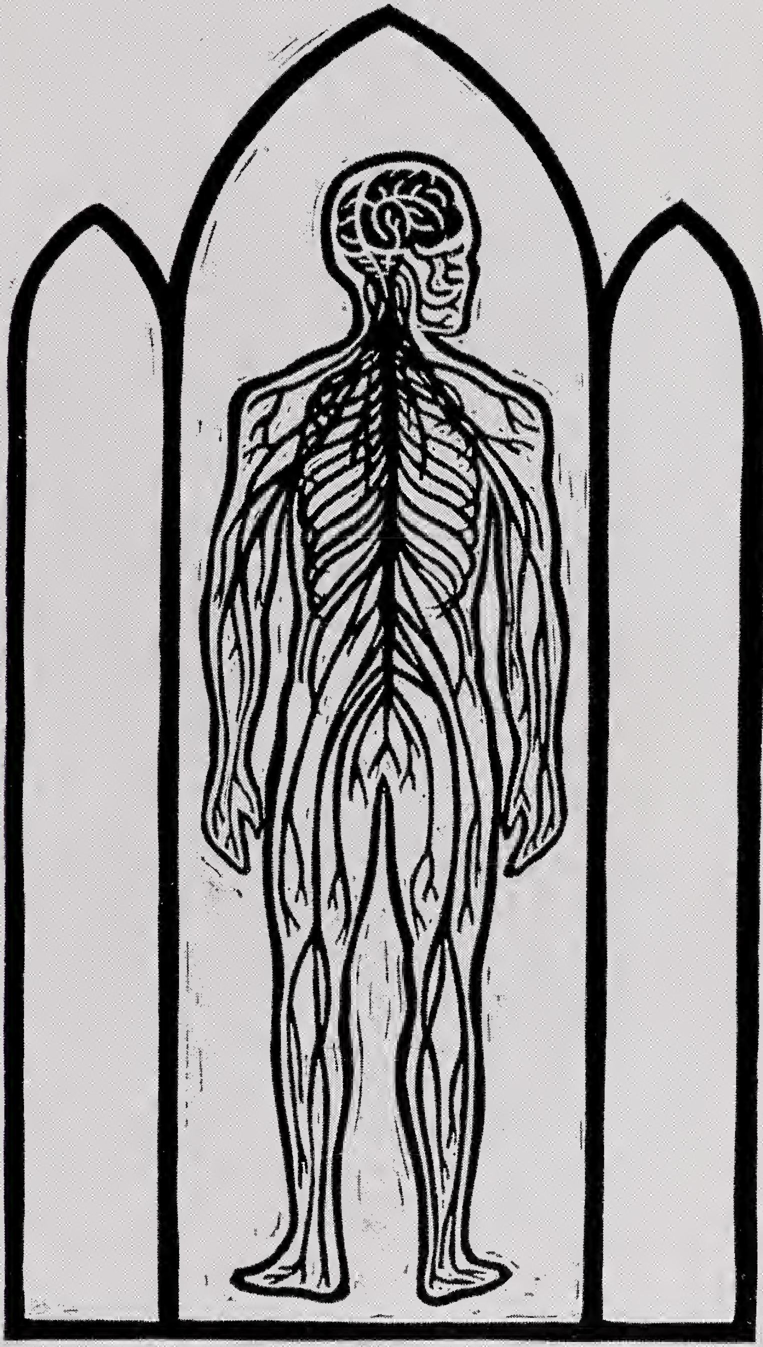
## THEMES SELECTED FOR CENTENNIAL SESSION

September 19-24, 1965—Detroit



*Sept. 19 - Medicine and Religion Day*

*Sept. 20 - Medicine and Business, Industry and Communications Day*

*Sept. 21 - Medicine and Medical Organization Day*

*Sept. 22 - Medicine and Science Day*

*Sept. 23 - Medicine and Voluntary Health Day*

*Sept. 24 - Medicine and Government Day*

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*Lennox, W. G.: Epilepsy and Related Disorders, Boston, Little, Brown and Company, 1960, vol. 2, p. 865.

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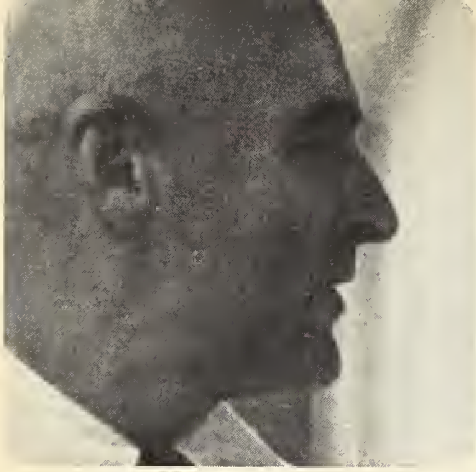

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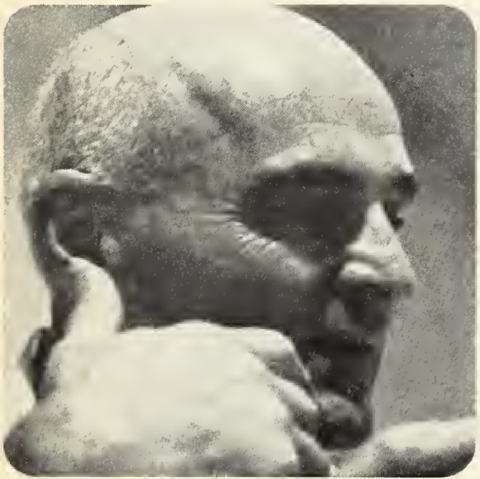

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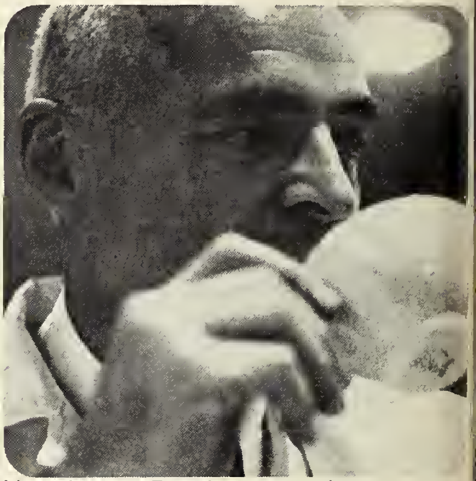

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*Contraindications:* History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.
*Warning:* Discontinue 2 weeks before general anesthesia, 1 week before electroshock therapy, and if depression or peptic ulcer occurs.
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For full details, see the complete prescribing information.

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*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone plus reserpine in moderately severe and severe hypertension: A two year study. Presented at the 7th Inter-American Congress of Cardiology, Montreal, June 14–19, 1964.

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the journal of the michigan state medical society

March 1965 · Vol. 64 · No. 3

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Published monthly except two extra issues to be published in October and December, by the Michigan State Medical Society as its official journal at 2642 University Avenue, Saint Paul, Minnesota 55114.

Second class postage paid at Saint Paul, Minnesota.

Yearly subscription rate, $9.00; single copies, 80 cents. Additional postage: Canada, $1.00 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year.

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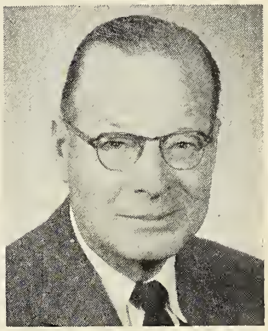
# *President's Message*

## AMA-ERF Up to You

By OLIVER B. McGILLICUDDY, M.D.
MSMS President

Challenge: Every month 500 applications pour in asking for financial help from the AMA-ERF (The AMA's Education and Research Foundation).

Solution: The solution hinges on the response from Michigan physicians and those from other states to contribute to the AMA-ERF Loan Program.



Michigan has a proud record of contributions. It can be maintained and continued only if each of us recognizes this responsibility—and opportunity. Your Michigan State Medical Society is one of several state societies which has participated with an every-member effort. Upon action of the MSMS House of Delegates, each MSMS member contributed $10 during 1963. Many physicians contribute every year. The Woman's Auxiliary to MSMS also has provided fine support.

More than 500 Michigan students have been assisted by the AMA-ERF. Total amount loaned to them is considerably over $500,000.

The AMA-ERF recently observed its third birthday and points with pride to its 36-month-performance. The guaranteed loan program already has assisted more than 11,000 medical students, interns and residents.

Your check to the AMA-ERF, at 535 N. Dearborn Street, Chicago, Illinois, 60610, will multiply fast, and almost unbelievably. It works this way—Banks can lend $12.50 for every dollar in the Fund, and so far industry has matched physician contributions dollar for dollar in building this fund. Thus, your contribution is worth $25 on the dollar.

There is a second phase to the AMA-ERF which permits the Foundation to make allocations to research projects. The AMA Institute for Biomedical Research, which opens this summer, is one of the fine, new research efforts.

Contributions may be given unrestricted to the AMA-ERF to permit them flexiblity to allocate the contributions as warranted by current needs; or contributions may be earmarked for specific medical schools.

Your continued, enthusiastic support of the AMA-ERF project is one way that you can help support this worthwhile program in medical education and research.

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*Dosage:* Adults—250 mg. every six hours in respiratory infections; 500 mg. every six hours in urinary and gastrointestinal infections (higher doses may be needed in severe infections). Children—(under 13 years, whose weight will not result in a dosage higher than that recommended for adults) 100 mg./Kg./day in divided doses every six or eight hours; 200 mg./Kg./day in divided doses every six hours for severe infections.

*Contraindications:* (1) Hypersensitivity to penicillin. (2) Infections by penicillinase-producing staphylococci and other penicillinase-producing organisms. *Aerobacter aerogenes, Pseudomonas pyocyanea,* and *Proteus morganii* are resistant to PENBRITIN (ampicillin).

*Side Effects:* Mild effects, such as skin rashes, diarrhea, nausea and vomiting have occasionally appeared.

*Precautions:* As with other antibiotics, precautions should be taken against gastrointestinal superinfection. To date, safety for use in pregnancy has not been established.

*Supplied:* No. 606—Each capsule contains 250 mg. of ampicillin. Bottles of 16 and 100.

*References:* 1. Rolinson, G. N., and Stevens, S.: Brit. M. J. *ii*:191 (July 22) 1961. 2. Editorial. Lancet *ii*:723 (Oct. 5) 1963. 3. Parker, M. T., *et al.:* Brit. M. J. *i*:1550, 1962. 4. Evans, W., and Hansman, D.: Lancet *i*:451 (Feb. 23) 1963. 5. Richards, J. D. M., and Rycroft, J. A.: Lancet *i*:553 (March 9) 1963. 6. Schaedler, R. W., *et al.:* New England J. Med. *270*:127 (Jan. 16) 1964. 7. Howard, P., and Riley, H. D., Jr.: Abstracts, Fourth Interscience Conference on Antimicrobial Agents and Chemotherapy, Oct. 26-28, 1964, New York, N.Y.

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## INFORMATION FOR READERS / CONTRIBUTORS:

### GENERAL INFORMATION:

Michigan Medicine is the official organ of the Michigan State Medical Society, published monthly under the direction of the Publication Committee. A copy is sent to each member of the Society.

*Notice of change of address should be sent promptly to the Michigan State Medical Society, P.O. Box 152, East Lansing, Michigan.*

Members are invited to submit to the Journal any suggestions for the welfare of the Society, as well as comments or criticisms of any material in the Journal. All such communications should be directed to the Publication Committee of the Journal. The Publication Committee reserves the right to publish, reject, edit, or abbreviate all communications submitted to it.

### ADVICE TO AUTHORS:

1. Address scientific manuscripts to Editor, Michigan Medicine, C. J. Tupper, M.D., 2490 Adare, Ann Arbor, Michigan.

2. Submit original, double-spaced, typewritten copy and one carbon copy on letter size (8½ x 11 inch) paper.

3. On page one, include title, authors, degrees, academic titles, and any institutional or other credits.

4. Authors are responsible for all statements, methods, and conclusions. These may or may not be in harmony with the views of the Editorial Staff. It is hoped that authors may have as wide latitude as space available and general policy will permit. The Publication Committee expressly reserves the right to alter or reject any manuscript, or any contribution, whether solicited or not.

5. Illustrations should be submitted in the form of glossy prints or original sketches from which cuts, or plates, will be made by the Journal. The Journal will pay the first $25 of the engraving bill, and the author shall pay the balance. An estimate of the cost will be submitted to authors before cuts are ordered.

6. References will ordinarily be limited to seven in number. Exceptions may occasionally be made.

7. Contributors will be notified as soon as practicable if a manuscript is accepted for publication. Unused manuscripts will be returned. Every care will be taken with the submitted material but the Journal will not hold itself responsible for loss or damage to manuscripts.

8. Articles should ordinarily be less than four printed pages in length (3000 words).

9. References should conform to *Cumulative Index Medicus*, including, in order: Author, title, journal, volume number, page, and year. Book references should include editors, edition, publisher, and place of publication, as well.

10. Specify address to which galley proof should be sent. Proofs will be mailed to authors for correction before publication and should be returned to the editor in 48 hours. If proofs approved by the author are not received by the editor prior to deadline, publication of the article will be cancelled for that issue.

11. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.

12. It is understood that material is submitted for exclusive publication in Michigan Medicine.

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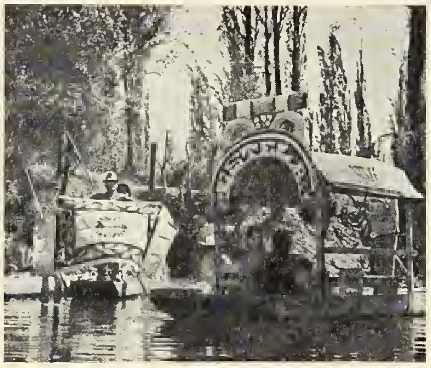

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[1] Clinical report on file, Medical Department, A. H. Robins Co., Inc.

[2] Schiller, I. W. and Lowell, F. C.: New England J. Med. 261:478, 1959.

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See product literature for complete prescribing information.

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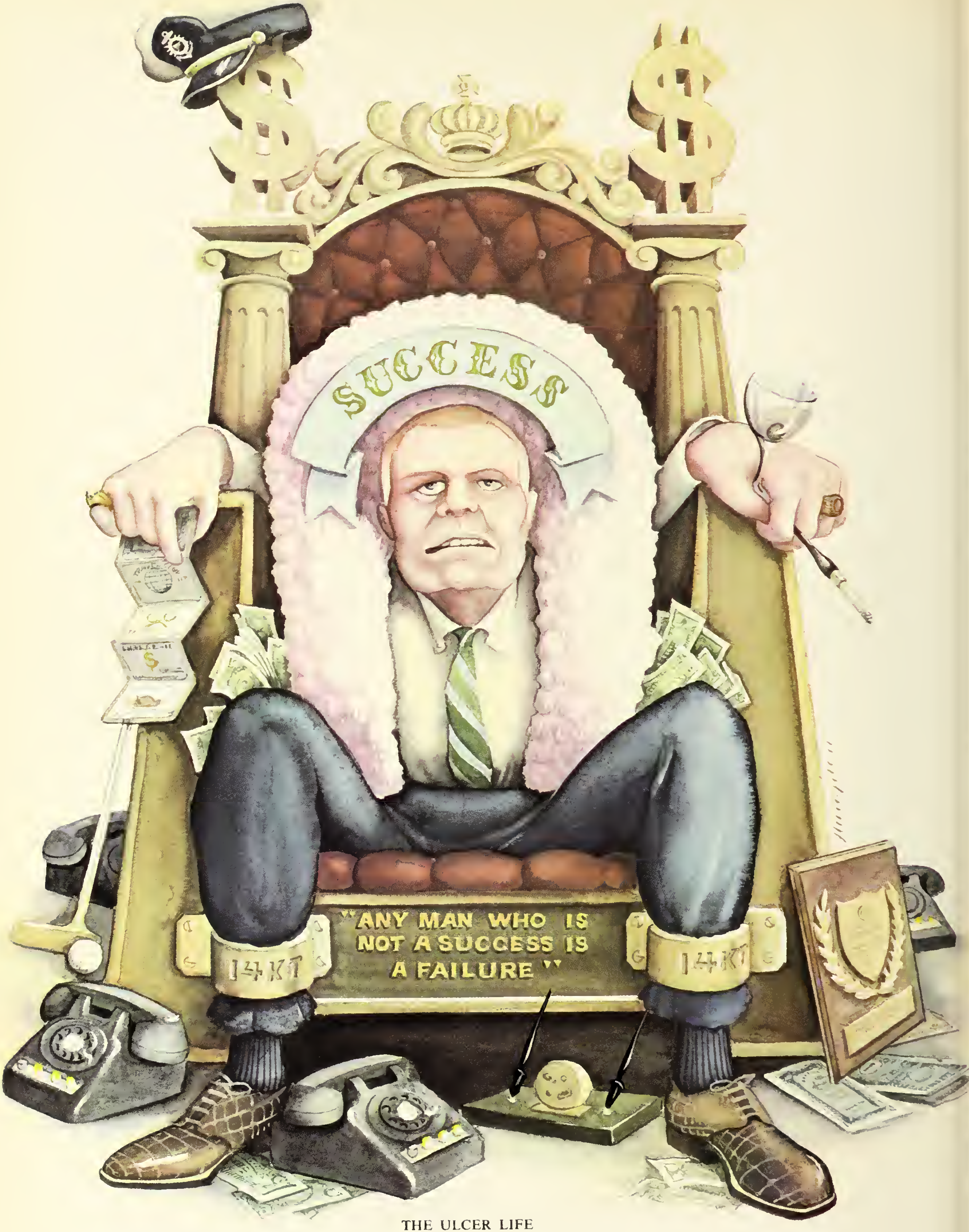
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REFERENCES: 1. Epstein, J. H.: Am. J. of Gastroent., 37:295, March, 1962. 2. Breidenbach, W. C.: Investigative Clinical Report, March, 1961. 3. Young, R., and Sun, D. C. H.: Ann. N. Y. Acad. Sc., 99:174, Feb., 1962. 4 Slanger, A.: Journal of New Drugs, 2:215, July-Aug., 1962. 5. Posey, E. L., Jr.: Am. J. Dig. Dis., 7:863, Oct., 1962.

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# NEWS BRIEFS

The program for the Sectional Meeting of the American College of Surgeons at Philadelphia February 15 listed as speakers—**D. Emerick Szilagyi, M.D.**, Detroit; **Richard C. Schneider, M.D.**, Ann Arbor; **E. S. Gurdjian, M.D.**, Detroit, and **Robert C. Bassett, M. D.**, Lansing.

**Joan C. Stryker, M. D.**, Wyandotte, discussed "The Population Explosion in the Orient" before the Wyandotte AAUW. She formerly served in the Far East with the UN Emergency Fund.

**Charles O. Long, Jr., M. D.**, and **D. B. Hiscoe, M. D.**, both of Lansing, discussed smoking and health at a MSU program sponsored by the MSU Pre-Medical Society.

A grant of $59,349 has been received from the U. S. Public Health Service by the Wayne Neurological Center for Cerebrovascular Research, directed by **John S. Meyer, M. D.**, chairman of the Neurology department.

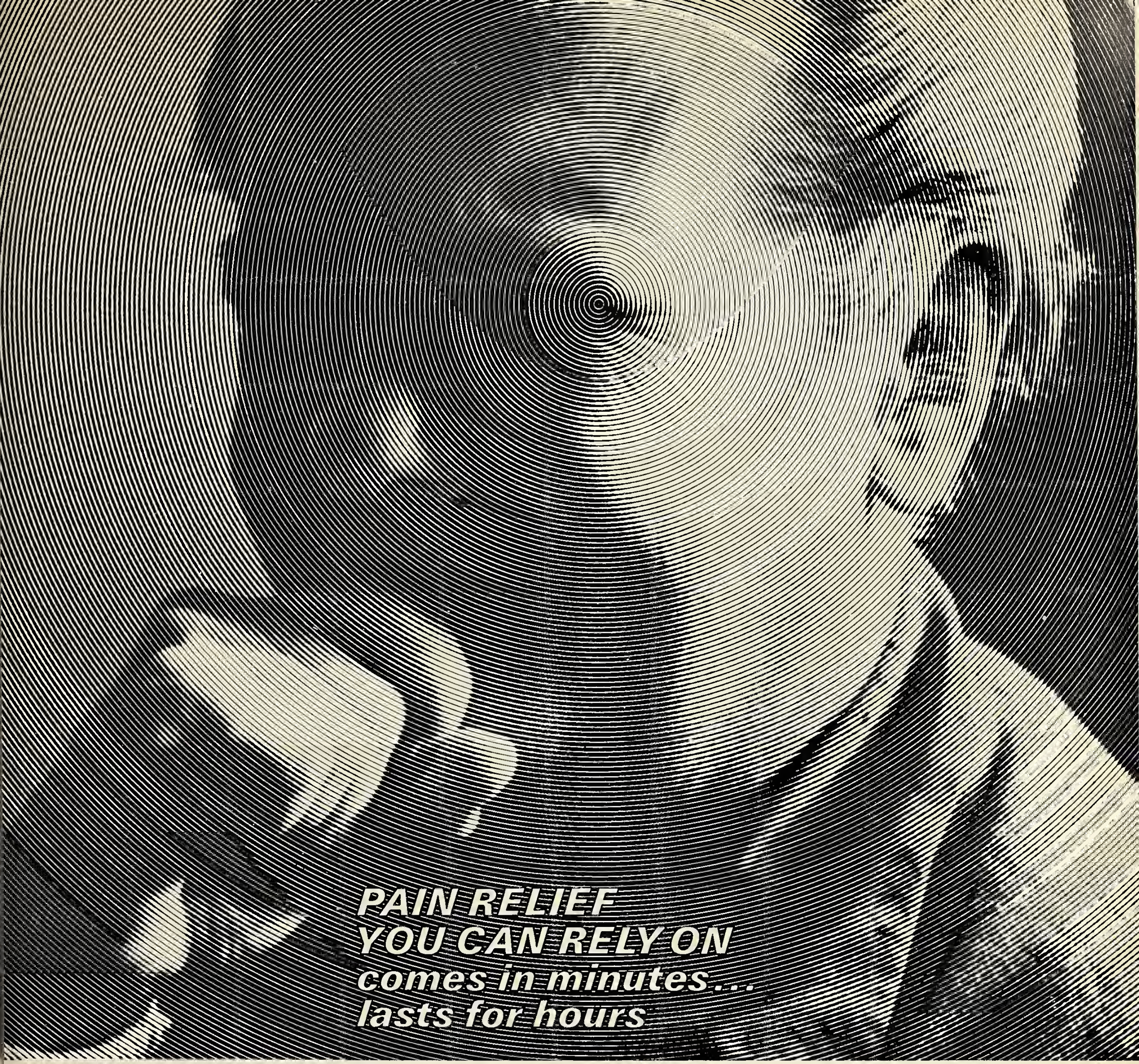
**David Jacknow, M. D.**, Detroit, has been elected a new regional vice president of the Phi Lambda Kappa Medical Fraternity. **Norman R. Schakne, M.D.**, Detroit, was named a trustee.

**James C. Breneman, M. D.**, Galesburg, has been awarded the 1964-65 Honors Achievement Award from the Angiology Research Foundation and the Purdue Frederick Company for "distinguished accomplishments in the research and study of angiology." His published work was in the use of computers for predicting postoperative thromboembolic disease.

**John H. Young, M. D.**, Traverse City, is the new director of the Northwest Michigan Child Guidance Clinic. He has been on the staff of the Traverse City State Hospital since 1959.

**Lester J. Evans, M. D., LL.D.**, former executive associate for medical affairs of the Commonwealth Fund, has been named a visiting professor for the Michigan State University College of Human Medicine. Dr. Evans is the author of a recent book, "The Crisis in Medical Education," in which he discusses his idea for improving medical education. The book

*(Continued on Page 158)*



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**Literature on request.**
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(Continued from Page 156)

is based on the William W. Cook lectures delivered by Doctor Evans in November, 1963, at the University of Michigan.

**Frederic B. House, M. D.**, Ann Arbor, is a new member of the board of directors of the Ann Arbor Chamber of Commerce.

**E. Richard Harrell, Jr., M. D.**, Ann Arbor, has been elected a member of the 15-man board of directors of the American Academy of Dermatology.

Contributions are being received by Ernest Gardner, M. D., Dean of the Wayne State University School of Medicine, for a memorial fund to honor **Ferdinando A. Morin, M. D.**, late chairman of the WSU anatomy department. The fund will aid medical students.

**Edwin DeJongh, M. D.**, Pontiac, has been named associate medical director of General Motors. Doctor DeJongh, medical director of Pontiac Division since 1957, succeeds **Earl F. Lutz, M.D.**, Detroit, who retired.

The Port Huron Chamber of Commerce at its annual banquet presented a plaque to **Armin T. Franke, M. D.**, as chairman of the St. Clair County "Operation Sugar Cube." The project served 64,000 residents.

**Stanley Robinson, M.D.**, has been chosen as "Distinguished Service Award" recipient by the Grand Ledge Jaycees.

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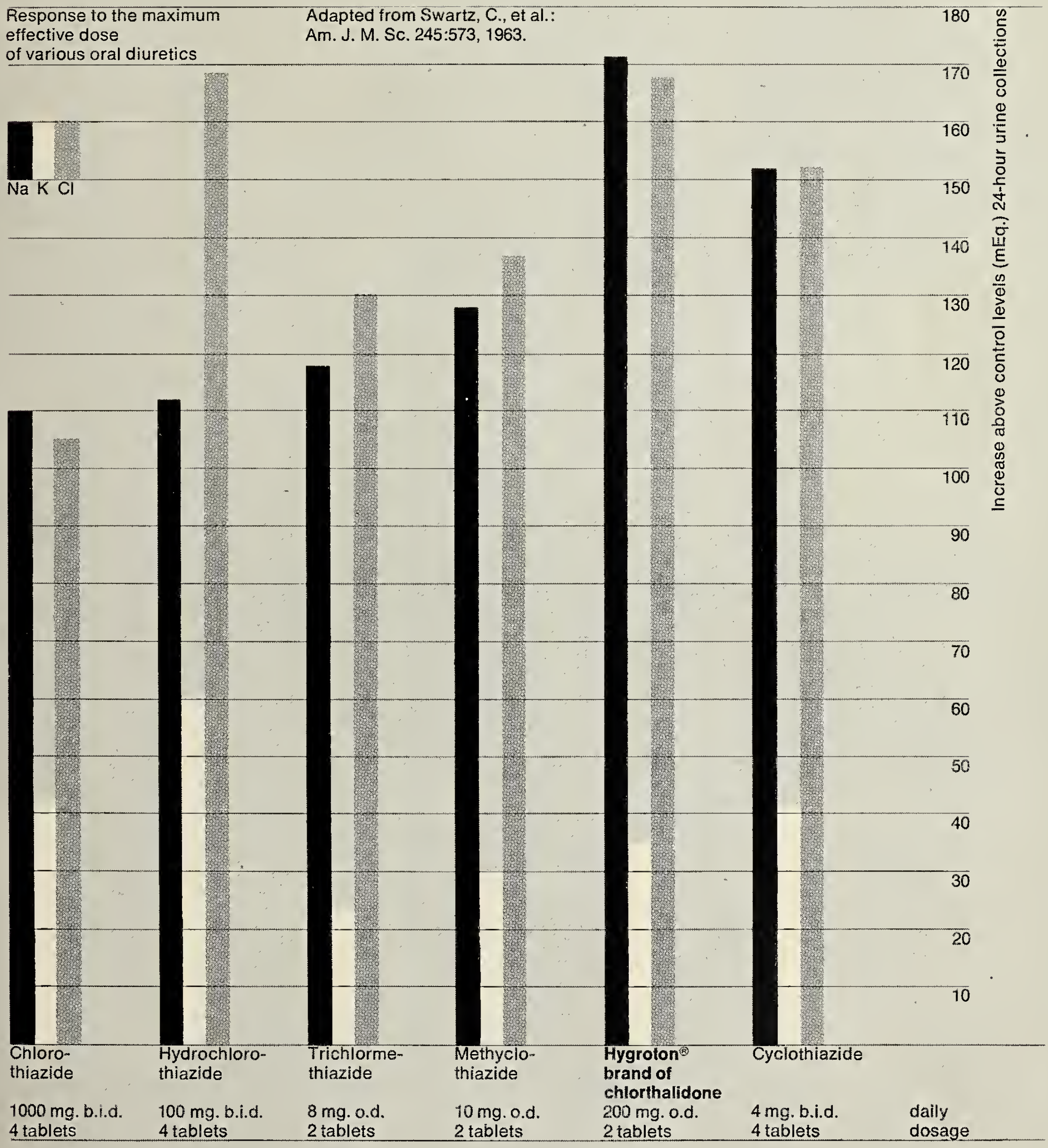

# Welcome, New Members!

**Eugene M. Britt, Ph.D.**
2207 N. Circle Drive
Ann Arbor, Michigan
*Bacteriology*

**Richard U. Byerrum, Ph.D.**
602 Wildwood Drive
East Lansing, Michigan

**Joseph Campbell, M.D.**
Bixby Hospital
Adrian, Michigan
*Radiology*

**Harold E. Crow, M.D.**
2909 E. Grand River Avenue
Suite 211
Lansing, Michigan
*General Practice*

**William R. Eppler, M.D.**
Detroit Receiving Hospital
Detroit, Michigan

**Hans Fischer, M.D.**
Standish, Michigan

**M. Galliani, M.D.**
Bixby Hospital
Adrian, Michigan
*Anesthesiology*

**Richard H. Gascoigne, M.D.**
693 Stockford Drive
Adrian, Michigan
*Surgery*

**Edward A. Glenn, M.D.**
2827 Briarcliff
Ann Arbor, Michigan
*Psychiatry*

**Bahram Khodadadeh, M.D.**
4252 Orchard Lake Road
Orchard Lake, Michigan
*Pediatrics*

**William H. Knisely, M.D.**
732 Oakwood Drive
East Lansing, Michigan

**Natalio Kogan, M.D.**
Sinai Hospital
Detroit 35, Michigan

**Fred Lee, M.D.**
1316 GlenLeven Drive
Ann Arbor, Michigan
*Roentgenology & Radiology*

**Hari B. Mankani, M.D.**
Herman Kiefer Hospital
Detroit 2, Michigan

**Marvin O. Margolis, M.D.**
Herman Kiefer Hospital
Detroit, Michigan

**Perry L. Mathis, M.D.**
3239 Clements
Detroit 38, Michigan

**Mary Louise Mayer, M.D.**
22631 Greater Mack
St. Clair Shores, Michigan
*Pediatrics*

**W. E. Barry Mayo, M.D.**
2338 N. Woodward Avenue
Royal Oak, Michigan 48073
*Orthopedic Surgery*

**A. Karim Shaalan, M.D.**
Doctor's Hospital
Detroit 7, Michigan
*Surgery*

**Yehya A. Shawky, M.D.**
8425 E. Twelve Mile Road
Warren, Michigan
*Pediatrics*

**Marshall L. Shearer, Jr., M.D.**
8044 Dexter-Pinckney Road
Dexter, Michigan
*Psychiatry*

**John L. Shields, M.D.**
234 W. Caroline Street
Fenton, Michigan
*Internal Medicine*

**Harvey O. J. Small, M.D.**
Elliott General Hospital
Detroit, Michigan

**William K. Stewart, M.D.**
403 Ann Street
Union City, Michigan

**Jon L. Stolte, M.D.**
955 N. Cass Lake Road
Apt. 215
Pontiac, Michigan

**Ronald L. Stuk, M.D.**
Medical Arts Center
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*Radiology*

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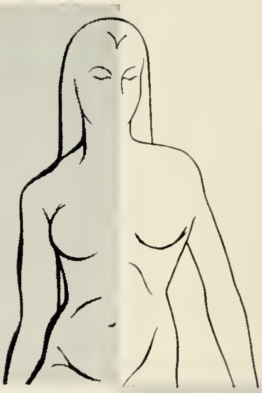

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[1] Nathan, L. A.: Exhibit presented at Mich. Acad. Gen. Pract., Detroit, Mich., Nov. 10-12, 1961.

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All precautions applicable to intramuscular injection should be carefully observed. Intramuscular solutions should be injected well within the body of a relatively large muscle, such as the upper outer quadrant of the buttock or the lateral thigh; do not inject into the lower or middle thirds of the upper arm. Care should always be taken to avoid injecting into a blood vessel or major nerve. Subcutaneous or fat-layer injection should be avoided.

**Adverse Reactions:** Nausea, diarrhea, glossitis, stomatitis, proctitis, vaginitis and dermatitis, as well as reactions of an allergic nature, may occur but are rare.

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[1] Griffith, R.S., and Black, H.R.: Current Ther. Res., *6:* 253, 1964.

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# Brain Tumors

By **HARVEY GASS, M.D.**
**Detroit**

There is considerable confusion in the minds of many physicians concerning the prognosis for patients with brain tumor due to the low incidence of this disease in most non-neurological practices. This paper surveys the results of treatment of 100 consecutive patients with brain tumor treated by a single surgeon at a single hospital, emphasizing the variety of factors which may influence the outcome.

A patient suffering from a malignant brain tumor which has rendered him seriously neurologically disabled is a disheartening spectacle.

Every hospital where neurosurgery is done will have patients of this kind from time to time in its beds. Hospital personnel and physicians with only casual contact with such patients may retain this image as representative of the results of brain tumor surgery.

Patients with more favorable tumors and even some with malignant ones but whose symptoms may be initially reversible are often discharged from the hospital early in their postoperative course and are not remembered.

Too often this set of circumstances produces a distorted or confused impression about the prognosis of intracranial surgery for cerebral neoplasm.

* * *

IN THIS REPORT, 100 patients are presented who represent consecutive operations for brain tumor by a single surgeon at a single hospital.[*]

This represents almost the total hospital experience with brain tumor surgery during the interval in which these hundred patients were hospitalized. Certain variables which theoretically might affect the statistical outcome in a series of patients of this kind such as inconstancy of technique, judgement, skill and experience due to participation of several surgeons are thus eliminated and a truer estimate of prognosis can be had.

One source of confusion about the subject of brain tumors in the minds of many physicians who do not have special knowledge in the field of neurology is the complexity of diagnosis and pathology of intracranial neoplasia.

* * *

THE COVERT nature by which these lesions may present themselves and the extreme variability of histopathological types that are possible within

**SCIENTIFIC PAPERS**

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Doctor Gass is Clinical Associate Professor of Neurological Surgery, Wayne State University. Statistics were compiled by Howard Molitz. This project was supported by the Research Fund of Sinai Hospital of Detroit.

[*] Sinai Hospital of Detroit.

the cranial cavity demand special vigilance and knowledge for clarity of the clinical diagnosis in such patients. The number of different tissues which may give rise to neoplasms within the cranium are many: geographical locations of such lesions vary as to accessibility and gravity; disability may be determined not only by the specific neuroanatomical pathways involved by the process, but by the additional influence of the intolerance of the brain to increasing intracranial pressure; the age and even sex of the host may influence diagnostic and prognostic considerations; rate of growth may vary according to the malignant potential of the neoplasm; and in addition to all the foregoing factors there may be variability in the growth rate and outcome dependent upon the biological course and critical location of certain special types of tumors.

There is no other tissue, organ or system in the body which is heir to such a kaleidoscopic array of factors which play important roles in determining the outcome of the disease process. Thus, there is little meaning in a prognosis offered for surgery for brain tumor without elucidation of many of these factors. In the 100 cases reported herein, attention is directed primarily to surgical results with respect to several of these variable factors. However, analysis of a far larger series than this would be needed to achieve ultimate surgical prognostic accuracy with respect to all the variables inherent in the problem of intracranial neoplasms. At least 1 year has elapsed since the last of these 100 patients has been operated on.

## Case Material

Of the 100 patients in this series, 53 were male and 47 female. The patients' ages varied from 5 to 75. There were 10 patients 14 years and under. There were 3 patients over 70 years of age. As indicated in Table I, there were 5 patients in the first decade of life, 8 in the second, 7 in the third, 11 in the fourth, 21 in the fifth, 28 in the sixth, 17 in the seventh and 3 in the eighth decade of life.

The only factor that might be at work in weighing the age distribution against a higher index of pediatric cases would be the attraction that the Children's Hospital of Michigan, located in Detroit, would have in drawing gravely-ill children. Forty-nine of the patients, or about half of them, fell between the ages of 41 and 60.

## Mortality

Mortality was divided into postoperative and late. A late mortality was considered to be a death which occurred a long time after the operative procedure and one in which the operation itself was not considered to have influenced its occurrence. A postoperative death was one which occurred immediately following surgery or which terminated a rapidly deteriorating course precipitated by the surgery.

In a few instances, special note was made of the fact that such a termination occurred in a preoperatively moribund patient who represented the end stages of his disease and it was felt that death was imminent and would have occurred even had the surgery not been performed.

On the basis of this classification, reference to Table II reveals that of the 100 operative patients, 18 suffered postoperative death. Two of these, however, were considered to be the result of the patient's disease and were not properly chargeable to the surgical procedure per se. There was thus a corrected operative mortality of 16 per cent. With respect to the pediatric and geriatric age groups, there was 1 postoperative death of the 5 children in the first decade of life, and of the 10 children less than 14 years of age there was only 1 postoperative death. Of the 3 patients between the ages of 71 and 75, there was 1 postoperative death, and this was felt to be due to the far-advanced stage of the patient's disease rather than to the surgical procedure.

## Overall Survival

Of the 82 patients surviving the early postoperative period, as of this writing, 31 patients are known to have died. Two additional patients who have been lost to follow up are presumed to have died inasmuch as they harbored metastatic brain lesions. Thus, there were 49 patients who were known to be alive at least a year following the operative procedure. Of the 31 late-death patients on whom a follow up was available, one patient survived between 3 and 4 years, 1 patient between 2 and 3 years, 6 patients between 1 and 2 years, 10 patients between 6 months and a year and the remainder died within less than 6 months following surgery. In other words, of the 31 known late-death patients, 8 survived more than a year, so that 57 patients are known to have lived for at least 1 year after the operation.

## Survival by Histological Type

Table I shows a breakdown of the 100 cases into histological types. If we consider meningiomas, acoustic neuromas, craniopharyngiomas, pituitary adenomas, colloid cysts and dermoid cysts as histologically benign, then of the 100 tumors, 54 were histologically benign. This, of course, did not mean that they were all curable lesions since some

TABLE I.

| Age | Astrocytoma | Meningioma | Pituitary | Metastatic | Acoustic Neuroma | Craniopharyngioma | Oligodendroglioma | Ependymoma | Colloid Cyst | Dermoid | Medulloblastoma | Hemangioblastoma | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-10 | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 5 |
| 11-20 | 2 | 0 | 2 | 0 | 1 | 0 | 0 | 1 | 0 | 2 | 0 | 0 | 8 |
| 21-30 | 0 | 2 | 2 | 0 | 1 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 7 |
| 31-40 | 4 | 4 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 11 |
| 41-50 | 5 | 6 | 3 | 2 | 2 | 0 | 1 | 0 | 1 | 0 | 0 | 1 | 21 |
| 51-60 | 11 | 11 | 2 | 3 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 28 |
| 61-70 | 6 | 6 | 1 | 2 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 17 |
| 71-80 | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 |
| Total | 32 | 30 | 12 | 8 | 6 | 2 | 2 | 2 | 2 | 2 | 1 | 1 | 100 |

TABLE II. MORTALITY

| | Astrocytoma | Meningioma | Pituitary | Metastatic | Acoustic Neuroma | Craniopharyngioma | Oligodendroglioma | Ependymoma | Colloid Cyst | Dermoid | Medulloblastoma | Hemangioblastoma | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Post-operative | 6* | 5 | 2 | 3 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 18* |
| Late | 22 | 3 | 1 | 4 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 31 |
| Total | 28 | 8 | 3 | 7 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 1 | 49 |

*Two of these were not considered surgical deaths, due to moribund preoperative state.

of them were not accessible for safe total removal. This would be particularly true of the occasional meningioma, lying in the anterior portion of the posterior fossa and the craniopharyngiomas.

On the other hand, certain of the astrocytomas, which ordinarily might be considered to have a malignant potential, may upon occasion be permanently eradicated by surgery. In some circumstances, although not in this series, the ependyoma and certain of the other types in this series may be likewise surgically cured as well as certain other rare tumors not included in this group. This series had 30 per cent meningiomas which is somewhat in excess of the incidence in several other reported series.[1-4] This increase is reflected in the somewhat lower incidence of astrocytomas in this series compared to others.

Of the 54 histologically benign tumors to which reference has been made, there were 7 postoperative deaths. In addition, there were 4 late deaths in this group, so that of 54 patients with histologically benign tumors, 11 of them died, 7 in a postoperative phase and 4 up to as long as 3 to 4 years after surgery.

Of these specific benign types, there were 5 postoperative and 3 late deaths among the 30 meningioma patients. Twenty-two are known to be living at least a year following the surgery, 3 for as long as 7 years. A total removal is believed to have been accomplished in all but 2 of these surviving patients, so that recurrence is not anticipated in those. In the 2 patients with incomplete removals, the tumor was a sphenoid wing meningioma in which the involved bone could not be totally removed, but relief of the symptoms has been accomplished which very likely will last their natural lifetime. There were no deaths among the 6 acoustic neuroma patients. In 5 of these a total removal was accomplished and in the sixth, because of the extensive cystic nature of it, a complete removal was not possible. In view of the slow insidious development of symptoms over more than a 10-year period in this patient, recurrence is not anticipated until after an interval of many years.

There were no deaths among the 2 craniopharyngioma patients; 1 of these represents a 5-year survival without recurrence and a total eradication of this lesion is believed to have been accomplished. In the other, a subtotal removal was obtained, but the past history of this patient indicates an extremely slow development of the lesion and many years may elapse before recurring troubles occur.

Among the 12 pituitary adenoma patients, one proved histologically to be malignant and this patient expired postoperatively. Of the remaining 11 patients, there was 1 other postoperative death and 1 late death 2 to 3 years following surgery and x-ray treatment.

There were no deaths among the 4 patients with colloid cysts and dermoid cysts. In 1 of the patients with a colloid cyst, a total removal has been accomplished, and in the second the diagnosis was not histologically verified and her condition was effectively treated by a shunt operation. Both patients with dermoid cysts have had total removals without incident.

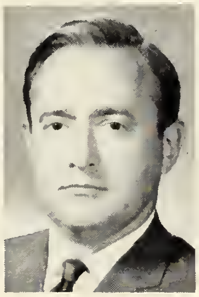
Among the 46 patients whose histological diagnosis suggests some potential for malignancy, there were 32 astrocytomas, 8 metastatic lesions, 2 oligodendrogliomas, 1 medulloblastoma, 2 ependymomas and 1 hemangioblastoma. When considering the histological type, astrocytoma, it is necessary to divide this group into at least 3 different clinical varieties since each of these varieties carries a different prognosis.

In adults, the most common form is the malignant hemispheric astrocytoma. There were 22 of these. For the 16 who survived the operative period, and for whom a followup is available, the average survival period was 8 months, the longest being 16 months. On the basis of gross surgical and histological findings, 4 patients were considered to represent the benign hemispheric form of astrocytoma generally carrying a much more favorable prognosis for longevity. One of these was operated upon in a moribund state and expired shortly after surgery. Another expired from recurrence 15 months after the original operation despite a repeat craniotomy 1 month prior to death. The tissue at the second operation appeared more malignant microscopically than at the first operation. It is not uncommon for these lesions to increase their malignancy with passing time. The other 2 patients were alive and well 51 and 25 months postoperatively.

A third category of astrocytoma, which is a distinct clinical group, is the cerebellar astrocytoma of childhood. This is often a cystic lesion with a mural nodule in its wall, the removal of which is often not difficult nor damaging and which generally accomplishes a cure. Although there were 6 astrocytomas of the posterior fossa in this series, none of them represented this cerebellar type in its pure form. Four of these were located within the fourth ventricle, 3 being in patients 18 years of age or younger. Two of them arose from the cerebellum and grew down into the fourth ventricle, both, however, being malignant histologically. One died immediately postoperatively and the other, 22 months postoperatively after local recurrence and spinal canal seeding. The other 2 arose from the floor of the fourth ventricle and grew up to fill it, both being histologically benign and 1 of them, the only 1 of the 6, was part cystic. The first of these 2 expired from a complicating postoperative meningitis, while the second was alive and well 7 years after surgery at the time of this report. The fifth patient, a child, had a malignant lesion deep in the cerebellum which was not accessible for radical removal, and expiration occurred 7 months later. In the sixth patient, an intra-pontine astrocytoma caused death 9 months after surgery.

Of the 8 metastatic lesions there were 3 postoperative deaths. Two additional patients died in less than 6 months and 1 died between 1 and 2 years postoperatively. Two patients are lost to followup.

Of the 2 patients with oligodendrogliomas, there was 1 postoperative death and 1 is surviving more than 7 years since the initial operation. He, however, has had two additional craniotomies in the interval. There is 1 medulloblastoma patient who is still alive more than 7 years since the surgery. Two ependymoma patients expired after incomplete removals between 6 months and a year after the operation. The patient with hemangioblastoma of her cerebellum died postoperatively.



The Author

H. HARVEY GASS, M.D.

## Functional Results

With regard to functional status of survivors, patients were considered to be intact if there was no functional disability nor any major problem with seizures. Of the 49 patients who were surviving a year or more after surgery, 36 were considered to be functionally intact. There were 13 who had some degree of invalidism.

*Of these 36 intact survivors, 34 are not expected to have a recurrence.*

Of the 13 partially-disabled survivors, 3 are definitely expected to have a recurrence and 1 might. Of 3 meningioma patients with partial disability, 1 has cortical blindness, another has a hemiplegia and a third has some difficulty in ambulation because of faulty equilibrium. In none of these is a recurrence expected. One patient with astrocytoma, in whom a recurrence is anticipated, has an aphasia. In 2 patients with acoustic neuromas, in whom total removal has been accomplished, disabling dysequilibrium exists and in a third a lesser degree of balance trouble is present which is possibly disabling. In 1 of the 2 patients with severe dysequilibrium, 2 previous craniotomies had been done elsewhere with incomplete removal of the tumor on each occasion; a total removal was accomplished in the last operation done in this series. In all, the acoustic neuroma patients, except for the 1 with the cystic lesion which was incompletely removed, some facial asymmetry exists due to disturbance of the facial nerve during surgery. In 1 of the 2 patients with craniopharyngioma, there is total blindness which had existed prior to the surgery for several years. One patient with an oligodendroglioma who has had 3 craniotomies and is expected to have another recurrence in the future has a moderately severe aphasia and right hemiparesis. Of 2 partially-disabled pituitary adenoma survivors, one, at the age of 71 has had several convulsions and the other has some symptomatic visual loss and temporary lapses of memory. One patient with a medulloblastoma who has survived 7 years is severly disabled and is mentally obtunded and unable to ambulate without assistance. One of the 2 patients with a colloid cyst has a left hemiparesis but this developed a few years subsequent to the operation coincident with an acute illness and jaundice. It is not disabling to her function as a housewife and mother. Thus, of the 13 partially-disabled surviving patients, 10 are not expected to have a recurrence. A serious disability exists in 8. In 7 of these, serious disabling symptoms existed preoperatively.

## Five-Year Results

Of the 100 patients, 42 were operated upon more than 5 years ago. Twenty of these are known to be alive and 1 additional patient, who had a total removal of meningioma and was well a year postoperatively and now lost to followup, is presumed to be still alive and well. Thus, 50 per cent of the 42 patients operated on 5 years or more ago are alive or believed to be alive. Of these, 16 are functioning without serious disability.

## Significance of Special Factors on Prognosis

Several other factors were surveyed to see if they had any prognostic significance with respect to type of tumor present or the surgical outcome. The duration of symptoms of tumor existing prior to admission was investigated. The approximate date of onset of the first symptoms which were referable to the tumor process were noted. The interval between this time and hospital admission was averaged for all patients with a given type of tumor. In the case of the pituitary adenomas the average time was 47 months. For acoustic neuromas it was 30 months, and 28 months for meningiomas. The astrocytomas averaged 4½ months, whereas the metastatic tumors averaged less than 2 months. The other types of tumor were too few in number for average figures to have any significance. It is apparent, however, for these larger groups, that one might favor malignancy if the duration of the present illness is only a few months and one might favor a benign lesion if it is a long present illness going back more than 2 years.

A patient presenting in stupor or coma because of a brain tumor usually reaches that state somewhat precipitously, either by rapid growth of the tumor or hemorrhage into it. Of 4 patients who were admitted to the hospital in this state, 3 proved to have astrocytomas and 1 a metastatic lesion, all malignant hemispheric lesions. Three of them, however, survived the operation and only 1 represented a postoperative death. Confusion, however, representing usually an extensive process, either in one or both frontal lobes or in the dominant hemisphere, may develop insidiously. Eighteen of the 100 patients presented with this type of manifestation. Eight of these were in benign lesions, 6 being meningiomas. The remaining 10 were in malignant lesions, 7 being hemispheric astrocytomas. The postoperative mortality in these 18 patients was 5. This is about twice the mortality rate of the entire series and might suggest, although the sampling is small, that the operative risk is somewhat greater when the patient is in a confused state. This may reflect the extensive nature of the process that generally produces this state.

There were 24 patients in the entire group who presented with papilledema. Only 3 of these died postoperatively. This would suggest that the presence of increased intracranial pressure does not necessarily increase the operative mortality. Only 24 patients of the entire group having papilledema would also indicate that currently we are finding brain tumors far earlier than was true a number of years ago when a high percentage of patients would have papilledema at the time of surgery. Twelve of the 24 patients with papilledema had benign lesions, seven of these being meningiomas. No trend, therefore, is evident regarding the prognostic significance of papilledema with respect to the benign or malignant nature of the tumor.

* * *

IT HAS LONG been the author's feeling that if brain tumor patients could be recognized earlier, such as at the time of their first symptoms, the operative mortality would be reduced and the possibility of a total cure increased.

Therefore, the group was investigated to see which patients were identified at the time of first symptoms before the progressive nature of the dis-

**You Read It First!**

"Condensed from Michigan Medicine" is the credit line that is being seen more and more in other medical journals. That is the line on page 1048 of the November, 1964, issue of "Current Medical Digest." CMD carried illustrations and copy from "The Common Finger Tip Injury," which appeared in Michigan Medicine, August, 1964. The article was written by William C. Grabb, M.D., and Reed O. Dingman, M.D., both of Ann Arbor.

ease became apparent. There were 8 patients of this type found. There was only 1 late death of this group, that occurring in a patient with a metastatic tumor. Six of the remaining are belived to be cured, 4 of meningioma, 1 of astrocytoma and 1 of a dermoid cyst and all are intact. The remaining patient with an oligodendroglioma is partially disabled but survives 7 years after the initial surgery. Six of these 8 patients, therefore, have been cured without deficit and a seventh represents a long term survival. It would seem quite clear that the effort for earlier diagnosis and treatment is rewarded by better results.

Procrastination with suspected brain tumor patients until intervention seems mandatory would, therefore, seem to be unwise.

A surprisingly low percentage of patients had a convulsive history. Actually, only 12 such patients were identified. Six of these had meningiomas. The tendency for these tumors to be on the surface of the brain and, therefore, a greater potential for convulsions may account for the somewhat higher incidence of seizures in this group of patients.

The plain skull x-rays were reviewed in 73 of the 100 patients. In 43 of them, positive findings were identifiable and in 30 the films were considered to be normal. These positive findings include shift of the pineal gland, abnormal calcifications, erosions, pathological hyperostosis, and enlarged sella turcica. Such positive findings were found in 13 meningioma patients, 11 pituitary adenoma patients and 8 astrocytoma patients. Thirty of these 43 patients with positive skull x-ray findings harbored histologically benign lesions. Only 13 with positive skull x-ray findings were in malignant tumor patients.

## Comment

Every physician who carries the responsibility for the management of a patient with a brain tumor must face the problem of prognosis in his patient. Since the treatment of most brain tumors is surgical, an integral component of this problem is the surgical mortality.

Equally pressing, perhaps, is the expected morbidity resulting from both the surgery and the disease process and of final importance is the life expectancy. Answers to questions in these matters may also have to give consideration to the influence which irradiation may bring to bear, since this mode of therapy may play some role though limited, in the management of intracranial neoplasms. The multiplicity of factors which play a part in determining the answers to these questions has already been referred to earlier.

A perusal of this series of 100 cases, draws attention to some of the factors which are important in formulating answers to the problems posed by prognosis.

Of all the variables involved in such determination, perhaps 2 are of greatest importance. The first is the histopathological type of the lesion and the second is its surgical accessibility. In some situations it is possible only on the basis of clinical examination to be fairly certain as to the exact type and location of the lesion. This might be true, for example, in a patient with a typical history and findings produced by an acoustic neuroma. Or at times, even with a pituitary adenoma, this may be possible. Reliable statements of prognosis may be made under these circumstances even without the aid of definitive or contrast studies of any type. In other circumstances, definite concepts about prognosis may be had prior to surgical intervention after completion of the contrast studies. For example, angiographic stain of a meningioma on the convexity of the brain or evidence of an anterior third ventricle tumor occluding the foramina of Monro, characteristic of a colloid cyst, each identifies specific clinico-pathological syndromes associated with fairly predictable prognoses. On the other hand, more often than we wish, even at the completion of all preoperative diagnostic studies, a great degree of uncertainty still exists with regard to histopathological type of mass lesion, even if the geographic localization is somewhat better understood.

It is apparent, therefore, that the diversity of factors influencing the outcome of brain tumor problems prohibits any blanket judgement about the outcome with respect to a particular patient harboring an expanding intracranial mass. In the present series, although 16 of the 100 patients expired as the result of the surgical intervention, on the other hand, 50 per cent of 42 patients operated upon, 5 or more years prior to preparation of this report, were believed to be alive and 16 of them were functioning without serious disability. It is, therefore, inaccurate to offer prognosis with regard to surgical mortality, morbidity or life expectancy except in those circumstances where sufficient information is available to eliminate many uncertainties.

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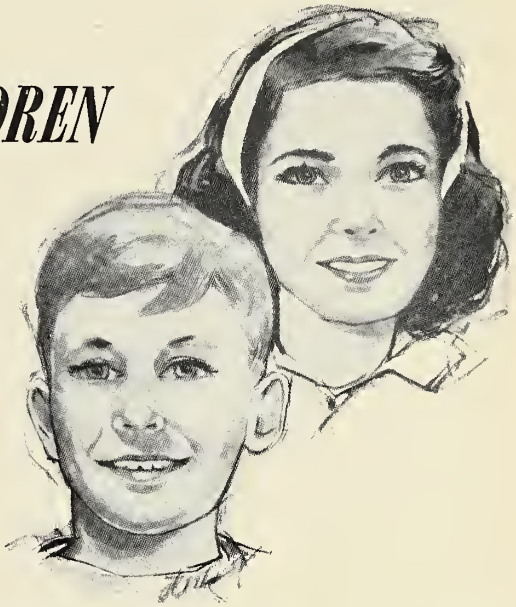
# The Physician's Role In the SEXUAL EDUCATION OF CHILDREN

The sexual education of children should take place through simple, direct answers to the child's natural questions. Such knowledge enhances the child's ability to master inevitable sexual impulses. Problems arise when parents are unable to give straightforward answers or when the inhibited child does not express this natural curiosity. Physicians are in an excellent position to help parents handle the sexual education of children. Unfortunately, there is a serious deficiency in current medical education which teaches little about sex beyond the anatomical level.



**By SAUL I. HARRISON, M.D.**
**Ann Arbor**

Whenever this subject of the physician's role in the sexual education of children is broached, there are almost invariably some questions raised by physicians.

The first is concerned with whether the physician ought to be involved at all in the sexual education of children for whom he does not have parental responsibility. In other words, do we as physicians, have a role distinct and separate from our obvious responsibilities as fathers and citizens. I agree wholeheartedly with the motivation underlying this question. Ideally, the sexual education of children should be left to the family. There is no question but that this is the best locus of such efforts under optimal circumstances. This, however, does not exclude the physician, for he is generally the only family health counselor available to the parents of pre-school children.

The next question then may be as to whether a preschooler is not too young for sexual education. To this we would answer that there is hardly a preschool child who does not ask questions, masturbate, and/or exhibit his genitals. Some physicians, agreeing with this, still maintain that this is not properly the physician's role, for while the physician is expert in the area of illness, this whole matter of sex is a moral issue.

* * *

THERE IS NO denying that in our culture it is next to impossible to separate sex and morality. If this is a reason for the physician to feel that sexual education is not within his province then we need to separate and distinguish *facts* about sex from *standards* of sexual behavior. Indeed, there should be no reason for confusion of these two. The facts are universal and unalterable, whereas the standards, despite some of our more cherished notions, are highly individual. But neither morality nor standards of behavior constitute our primary question, though they do lead to a question about sexual education that concerns many people. This is the issue of how the knowledge of the facts of sex affect morality and behavior.

We were all aware, even before the convincing Kinsey report, that moral standards and actual behavior were not always the same. Children have perceived this from time immemorial and the fact that our society has lost much of its authoritarian paternalistic influence has not eliminated the "do as I say; not as I do" approach to child rearing. If anything, we seem to have new influences that may

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Presented at the 1964 Symposium on Sex at the Michigan Clinical Institute, Detroit, Michigan.

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be more deleterious because it is harder for the child to sense the devilish ambiguities.

The prevalence of affluence, with its decreasing emphasis on the virtues of frugality and the delay of gratification, is seen in the decreasing influence of the primary family and religious standards. Our new value system advertises "do it now, and pay later" and the "good deal" becomes our goal.

In addition to these cultural influences there seems to be an increase in society's ancient conspiracy against children about sex. Sex is advertised by Madison Avenue as it never has been before; yet the parent's approach with the child in teaching him the names of his various body parts remains the same—exquisitely detailed from the top of the head to the umbilicus and from the knees to the tip of the toes, but neglecting names for anything between the umbilicus and the knees.

Some might argue that my discussion of changes in American society neglects to point out that teen-agers seemingly indulge in sexual behavior at an earlier age. Does this suggest that the sexual education they received must have put thoughts into their minds that might not have been there otherwise? We all know that children cannot play checkers until they are taught, so is it logical to think that our teaching them about sex is a way of teaching them how to play? Obviously, this is not entirely true for, unlike checkers, sex has an overriding biological basis. In addition, puberty comes earlier for today's children, just as basketball players today are taller and football players are heavier than they ever were before.

* * *

AS PHYSICIANS, it is time we stopped fretting so much about putting thoughts into people's minds. Iatrogenic difficulties are never induced by dealing with the issues that we know concern people. Telling the worried patient that his lesion was not cancer, even if he has not explicitly inquired, rarely introduces thoughts that were not there before. Though the psychiatrist who asks the melancholic patient if he has thought of suicide may be accused by the patient of putting thoughts into his mind, experience has taught most of us that it is only the people who are terrified of not being able to control their already existing suicidal thoughts who indulge in such accusations. Just as it is much easier for the depressed patient to deal with his thoughts of suicide if he has an opportunity to talk to an unthreatened, supportive person about them, so is every teen-ager in dire need of someone with whom to talk comfortably about sex.

The teen-ager may not tell us this about himself. Instead, he may admit to having a host of friends with such a need for someone with whom to talk. Ask a healthy teen-ager about the difference in the types of parties that he and his contemporaries had at different ages. He will laughingly recall elementary school birthday parties and talk in a rather self-assured manner about the dances sponsored by the junior high school. If you inquire about his comfort in relation to those dances, he will probably tell you that he enjoys them. If you ask him about the attitude of his friends regarding those same dances, however, you will likely hear him vividly and fervently describe discomforts and uncertainties, as long as he can claim that they were experienced by his friends and not by him.

* * *

IN THIS CONTEXT, the main question is whether biological urges are handled better with the reinforcement of information or whether they are handled better without the assistance of knowledge. The answer is unequivocally in favor of knowledge if we are interested in a form of control of biological urges that permits appropriate expression at the proper time in the proper place and with the proper person. In other words, if we are talking about a voluntary control and not a massive, wholesale suppression that may lead to problems in adulthood, then sexual education is an important adjunct to mastery of sexual urges. Viewed from that perspective, sexual education becomes a matter of preventive medicine and, therefore, is decidedly within the province of the physician.

There follows then an examination of the methods available for sexual education. Toddlers ask an endless variety of questions and the best way to respond to them is to answer the questions simply and directly. This seems valid whether they are inquiring as to why the sky is blue or the origin of babies. A simple and direct answer to the toddler's question about babies is that babies come from inside the mother. No additional elaboration is indicated because nothing else was asked. There will be further questions later, but they too should be answered in the same simple and direct fashion.

The little boy or girl who inquires as to why their playmates of the opposite sex are different is merely waiting to be told that children are born differently. Questions about how the baby got

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inside the mother will come later, but in a comfortable situation this will be a continuing, progressive process. Like all other learning, it will take time.

Responding to the toddler's first question by giving an extensive lecture about the facts of life (ending with a sigh of relief) is comparable to telling a child that today we are going to learn how to read, and then dropping the subject forever; or that today we are going to sit down and learn how to be a kind and good person, and that is going to be the end of that issue for evermore. Not only is such an approach ludicrous, but also it can overwhelm and frighten the child.

In sexual education, demonstrations are not indicated because sexual activity in our society, with the exception of certain affectionate gestures, is a private matter. We want to educate the children, not to stimulate them.

* * *

THE AVERAGE CHILD will set his own pace in keeping with his developmental phase. Like the teen-ager mentioned above, the messages conveyed often may be distorted. Thus, the young child who asks repeatedly about the origin of babies may be looking for reassurance about the normality of the anatomical differences between the sexes. Interest in menstruation, bodily changes, and nocturnal emissions may be expressed by pubertal children in the form of fearfulness about illness and/or a new-found interest in cleanliness. Discussing with the youngster the naturalness of pubescent changes, the fact that such changes are not a result of harm, and that nothing special needs to be done to earn them may prove to be amazingly reassuring at this age, regardless of what the child communicates.

Undoing the distortion in some of the child's messages requires that we help them to express their own ideas. The technique of communicating in "displacement," as illustrated before in asking the teen-ager about his friends, may be useful once again. It may be more productive to ask the child what he or she thought when they were younger rather than to inquire about his or her current thoughts or concerns. It may be helpful to tell them some of our own thoughts that we experienced when we were younger.

* * *

IT IS FAR EASIER to deal with the child who questions than with one who never displays such curiosity. In the latter instance either the child and/or his parents are in need of help. Developmental problems, such as mental deficiency, that might interfere with this natural universal curiosity are obvious and relatively easy to diagnose. More frequently, however, there may be emotionally-determined environmental factors, such as the parent's own discomfort with sexuality, that will either call for the physician's support and advice or even perhaps his volunteering to take over the educational function for the parents.

With older children there are several excellent books that can be recommended; the disadvantage of this approach, however, is that it tends to de-emotionalize the entire subject. Books, therefore, are best used as an opener for discussions in which emotions will not be neglected.

Obviously, it is my contention that physicians should align themselves with educators in an effort to help parents. In this context we should not forget that the physicians and educators, as well as the parents, may have been raised with dual sexual standards that may result in a variety of personal conflicts and discomforts. The best antidote for this is self-knowledge as the means of being one's own master. Implicit in the injunction "Physician heal thyself" is to know oneself.

Unfortunately, medical education, by and large, is not helpful in this regard. Though the laity thinks of us as experts on the subject of sex—we know that our medical education has been woefully deficient when we venture beyond the anatomical level in the area of sex. Compare our greater knowledge about the pathology effecting the U. in G.U. with our knowledge of the pathology effecting G.

* * *

IN FAR TOO many instances patients have been disappointed by the results of the medical profession's efforts to help them with their sexual problems.

Might this not be the explanation for the laity's tendency to turn to nonmedical sources of help? If this is so, there is no answer other than better education at all levels—medical school, internship and residency, and continuing postgraduate education. Many have objected to this recommendation, asserting that such a large measure of our knowledge about sex is probably mythological that it is not worth teaching.

My answer is that not only is there a wealth of nonmythological information that can be taught fruitfully, but that the best way to substitute facts for the guesses and wishes that constitute mythology is through research, which should be the inevitable companion of education.

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Intestinal obstruction is a common diagnosis in patients with abdominal complaints. The usual causes of small bowel and colon obstructions are well known.

There is, however, a group of diversified causes which uncommonly produce obstruction in the small and/or large bowel. Most of these require prompt surgery. Some of these situations have characteristic patterns of deformity on roentgen examination.

The salient clinical features of some uncommon cases of intestinal obstruction are reviewed.

# INTESTINAL OBSTRUCTION— A Review of Some Uncommon Causes

**By PAUL M. DASSEL, M.D.**
**Grand Rapids**

Intestinal obstruction is a common diagnosis by the clinician in the general practice of medicine and a frequent diagnosis by the abdominal surgeon or those with special interests in the gastrointestinal tract. In many cases the specific cause and location of an obstruction can be determined preoperatively. This knowledge is most helpful in planning the operative procedure.

Paralytic (inhibition) ileus is probably the most frequent cause of severe small bowel distention (obstruction) and may be either primary or occur postoperatively. The great majority of mechanical obstructions are caused by (1) adhesions and (2) hernias in the small bowel, and in the colon by (3) malignant neoplasms and (4) diverticulitis.

There is a significant group of miscellaneous causes which are uncommon but not rare. It is this latter group of uncommon causes that will be discussed, including: malignant neoplasm of the small intestine, volvulus of the colon, mesenteric infarction (vascular obstruction), gallbladder perforation, inflammatory stricture, foreign bodies and fecal obstruction.

Most of the uncommon cases of intestinal obstruction demand prompt surgery for survival, yet they often present only moderate or non-specific symptoms and clinical findings. Surgery is often delayed with a resultant high mortality. One must frequently review and constantly keep in mind the causes of intestinal obstruction in order to suspect the possibility of an unusual case when it is encountered.

X-ray examinations should be done early in the course of suspected intestinal obstruction. Scout films of the abdomen made in recumbent and upright or decubitus positions, and a chest film to show the diaphragm are the initial studies. It is possible to do these examinations on practically every patient, unless he is moribund. Progress x-ray films of the abdomen and the barium enema examination should be resorted to freely. The barium enema is particularly helpful in localization of obstruction and in establishing a specific diagnosis. A barium enema can be done on the majority of the patients and in particular situations with a minimum of preparation.

## Malignant Neoplasm Of the Small Intestine

Only 5 per cent of all primary neoplasm of the gastrointestinal tract occur in the small bowel (excluding the ampulla of Vater and the pancreas), and approximately one-third of these are malignant. Malignant tumors of the small bowel cause less than 1 per cent of small bowel mechanical obstructions, and most of these occur in the ileum.

The greatest incidence of carcinoma is in the sixth and seventh decades. Lymphomas occur in younger age groups. The symptoms of tumors of the small bowel are vague until the tumor is advanced. Eventually most malignant tumors will produce signs of gradually developing intermittent colic, distention, and vomiting. Severe anemia due to occult bleeding may occur, and on occasion there may be a massive gastrointestinal hemorrhage.

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Doctors C. P. Truog, B. R. Van Zwalenburg, P. M. Dassel, G. L. Bartek, and W. T. Lincer; Department of Radiology, Ferguson-Droste-Ferguson Hospital, Grand Rapids, Michigan.

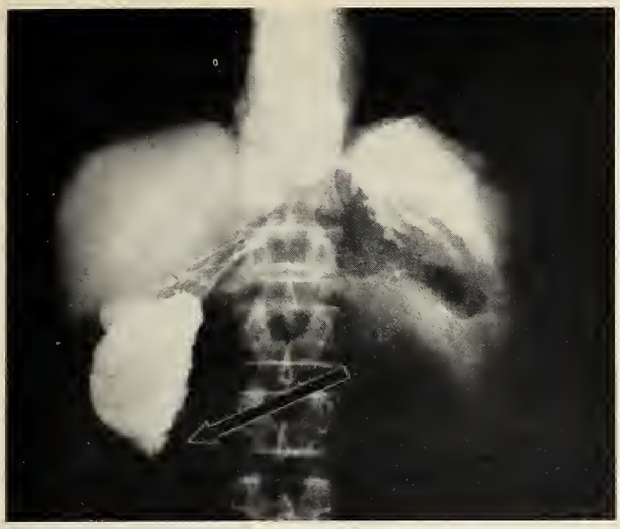

Fig. 1. Complete obstruction in the distal duodenum from a primary encircling neoplasm.

There is a palpable abdominal mass in about half of the cases. A history of unexplained progressive weight loss is often obtained.

Occult blood in the stool, in the absence of disease in the upper gastrointestinal tract and in the colon by x-ray examination, is an important positive finding in suspecting small bowel tumors. A detailed small bowel x-ray examination will establish the diagnosis in a large percentage of cases.

*Case No. 1.*—C. D., a 71-year-old man, was admitted with the complaints of general abdominal pain, cramping and nausea for a week. There were multiple previous hospital admissions for rectal bleeding. A segmental resection of the sigmoid segment of the colon for diverticular disease was done six weeks prior to this admission, but a systematic examination of the abdominal cavity at that time did not show any additional abnormality.

An upper gastrointestinal tract examination showed complete obstruction at the junction of the second and third portions of the duodenum (Fig. 1).

A constricting adenocarcinoma of the duodenum was resected.

*Comment: This case shows the difficulty in diagnosing a small bowel tumor before high-grade obstruction develops. There were frequent episodes of rectal bleeding which seemed to be adequately explained by the disease in the lower colon. The lesion was not detected at a recent abdominal exploration because of its inaccessible location.*

## Volvulus of the Colon

Volvulus of the sigmoid segment of the colon is the cause of 2 per cent of all cases of intestinal obstruction. There is a mortality of 25 per cent in operated cases, and a much higher mortality without surgery. The sigmoid is the usual site of volvulus in the colon; the cecum is second in frequency.

Volvulus is caused by a twist of a large mobile loop of bowel around one or two fixed points. Areas of fixation may be congenital or acquired. The twist may occur around normal ligaments and vessels.

Volvulus is essentially a closed loop obstruction which is prone to develop strangulation. The mechanism is that of progressive increasing distention and intraluminal fluid extravasation with eventual impairment of circulation and development of gangrene. Later, frank perforation and peritonitis occur.

Plain films of the abdomen are often diagnostic of volvulus. The barium enema will localize the anatomical site and positively confirm a suspected diagnosis of volvulus with an unusual pattern of bowel distention.

A sigmoid volvulus, on occasion, may reduce spontaneously or during a barium enema examination. Sometimes it is possible to relieve the distended loop by inserting a rectal tube through a sigmoidoscope. The deflated loop may then untwist.

*Case No. 2*—B. S., a 72-year-old white female, became ill 36 hours prior to admission. Initially there was pain in the left lower abdomen. During the next 12 to 24 hours, she developed considerable abdominal distention, nausea and vomiting. Examination showed marked abdominal distention. There was partial right hemiplegia from a previous cerebral vascular accident. Proctosigmoidscopy to 22 centimeters was negative.

Plain films of the abdomen showed marked distention of the colon, and especially of the cecum, which suggested volvulus. A barium enema following the initial x-rays showed an obstruction in the sigmoid with a twist deformity characteristic of volvulus. At surgery on the same day there was a 360 degree rotation of the sigmoid.

*Case No. 3.*—M. C., an 80-year-old white female, was admitted with a history of abdominal bloating for two weeks. Her last bowel movement had occurred several days previously. Examination showed marked abdominal distention. Bowel sounds were fair. Proctosigmoidoscopy to 25 cm. was negative.

A barium enema demonstrated sigmoid volvulus. The volvulus was reduced during the course of the enema and she expelled much gas and stool. The abdomen was reduced in size, but became moderately distended again two days later.

A laparotomy three days later showed a sigmoid volvulus secondary to a long polypoid and ulcerating carcinoma in the lower sigmoid. The sigmoid and cecum were markedly distended, but the small bowel was collapsed.

*Comment: Case No. 2 shows the value of the barium enema in localizing the site of the volvulus. The cecum showed the greatest distention but the twist was in the sigmoid.*

*The volvulus was reduced by barium enema in case No. 3, an uncommon event. A true volvulus had developed secondary to a primary tumor of the sigmoid. The ileocecal valve was competent and this in effect produced a second closed loop obstruction between the valve and the sigmoid volvulus.*

## Mesenteric Infarction

Mesenteric infarction causes about 1 per cent of all the cases of intestinal obstruction. It is the most common cause of gangrene of the bowel. The vascular occlusion may be either arterial or venous. Embolus from heart disease, thrombosis, arteriosclerosis, the postoperative state and a number of other disorders have resulted in vascular occlusion of the superior mesenteric artery and vein.

The superior mesenteric artery supplies the intestinal tract from the mid-duodenum to the splenic flexure of the colon. Occlusion of this vessel produces mesenteric infarction. Obstruction of this artery most often occurs near its origin in the aorta.

The onset of mesenteric thrombosis may be insidious or acute. Shock varies with acuteness and extent of the occlusion. Abdominal pain, diarrhea and severe vomiting are non-specific symptoms of vascular occlusion. Distention of the bowel may form characteristic patterns on x-ray examination.

Diagnosis is difficult and the abnormality may be confused with acute pancreatitis, acute cholecystitis or peptic ulceration. Aspiration of bloody ascitic fluid aids in establishing the diagnosis.

*Case No. 4.*—S. H. B., a 60-year-old white male, was hospitalized for investigation of an unexplained 30-pound weight loss during the previous several months. Extensive examination did not reveal the cause of the weight loss. A laparotomy was done for a presumptive diagnosis of neoplasm of the pancreas; however, no significant pathology was found.

On the ninth postoperative day he complained of abdominal pain and became moderately distended. Bowel sounds were not heard. His temperature rose to 100 degrees and the white blood count was 23,650. The following day the white count was 45,000.

Survey films of the abdomen three days later, showed intramural gas in multiple distended loops of small bowel indicating gangrene. He died on the thirtieth postoperative day.

Autopsy showed severe hemorrhagic infarction of the jejunum, ileum and proximal half of the colon from a thrombus which completely occluded the proximal two centimeters of the superior mesenteric artery. The thrombus was superimposed on advanced atherosclerotic plaques.

## Gallbladder Perforation

Perforation of the gallbladder occurs in about ten per cent of all cases of acute cholecystitis. This is an unpredictable and ominous complication with a mortality rate of 50 per cent. Perforation is often localized to the pericholecystic area, but may also occur into the peritoneal cavity. The mechanism of perforation is that of progressive distention. Inflammation of the gallbladder and obstruction of its duct, often by calculus, increases intraluminal pressure until it exceeds capillary pressure in the gallbladder wall. Necrosis and perforation follow impaired vascularity.

Most patients with perforation are in the seventh decade—almost all are over 50 years of age. The majority of patients with this complication are women. In one-half of the cases, perforation occurs within 72 hours after onset of illness. Most patients have a history of chronic cholecystitis. The usual symptoms are nausea, vomiting, and pain in the upper abdomen on the right. Jaundice is only occasionally present.

Gallstone ileus is a mechanical intestinal obstruction due to the obturator action of the gallstone in the intestinal tract. The gallstone may "grow" in size by intestinal contents clinging to its surface. Occlusion of the intestinal lumen usually occurs in the distal ileum. Gallstone ileus causes 2 per cent of all cases of intestinal obstruction. It is diagnosed preoperatively or antemortem in about one-third of the cases.

The gallstone usually enters the gastrointestinal tract by a cholecystoduodenal fistula, but sometimes passes directly into the stomach or the proximal transverse colon. The gallbladder becomes adherent to adjacent structures during previous episodes of cholecystitis. Recurrent inflammation of the gallbladder, combined with the irritating effect of the stone, produces erosion of the gallbladder

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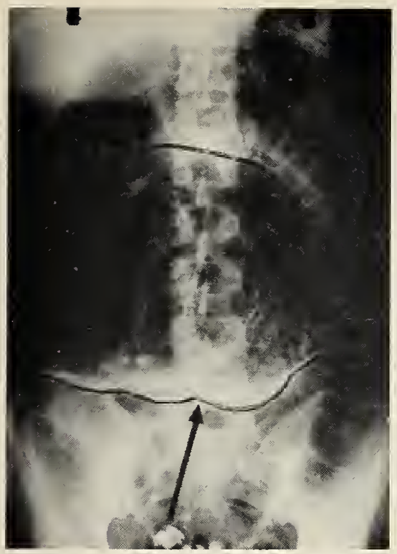

Fig. 2. Extreme distention of the cecum secondary to perforation of the gallbladder.

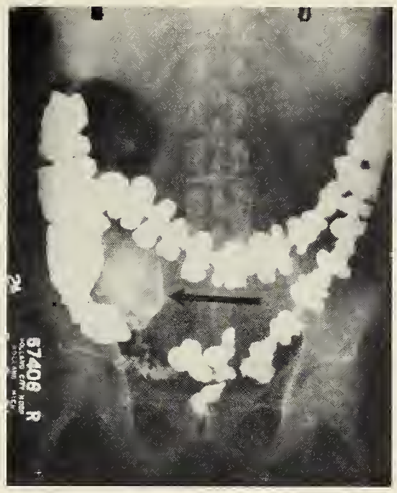

Fig. 3. Post-inflammatory stenosis in the distal ileum. The ileum is dilated (arrow) proximal to the stenotic area.

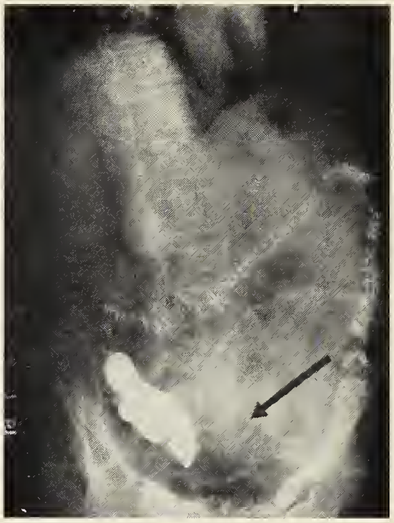

Fig. 4. Three opaque fruit pits are seen. They lie within the dilated ileum (represented by the dark areas in Fig. 3).

wall and then the duodenal wall allowing escape of the stone.

Most of the patients with gallstone ileus are between 60 and 80 years of age. This complication is ten times more frequent in women than in men. The mortality rate is 10 per cent.

Symptoms are the same as many other abdominal disorders; i.e., nausea, vomiting, cramping, abdominal pain and distention. Often the symptoms are minimal and may be acute or intermittent. Movement of the stone distally is accompanied by relief of symptoms. A history of previous cholecystitis can be obtained in only a little over half of the cases.

*Case No. 5.*—T. V. E., a 54-year-old white male, was hospitalized for pain in the upper abdomen on the right side for the past 24 hours. His white blood count on admission was 18,000. He was afebrile. A recent cholecystogram failed to show concentration of opaque dye in the gallbladder, indicating disease of the biliary system. A scout film revealed gross distention of the proximal colon and suggested volvulus of the cecum (Fig. 2). A cecostomy to relieve severe distention was done. The gallbladder was large and indurated.

He expired four days later. At autopsy the gallbladder was greatly distended with foul, turbid bile and contained a single cholesterol stone. The transverse colon was adherent to the gallbladder and there were three necrotic fistulae connecting these organs.

Infection appeared to be the principal element of obstruction.

*Case No. 6.*—H. B., a 63-year-old obese female was hospitalized for rectal bleeding. She appeared acutely ill and was very weak. The white blood count was 36,000 and the hematocrit 33 per cent.

A barium enema showed flattening and intermittent spasm of the superior surface of the proximal transverse colon adjacent to the inferior margin of the liver. Soon thereafter she passed per rectum three small gallstones and a large amount of blood. Five days later she died.

Autopsy showed a necrotic cavity in the upper abdomen containing the gallbladder and a large fistulous opening into the transverse colon. There were innumerable gallstones and the common duct was blocked by five calculi. Microscopic examination revealed adenocarcinoma of the gallbladder with metastasis to the liver.

*Comment: In Case No. 5, the outstanding finding was tremendous dilatation of the proximal colon suggesting obstruction secondary to volvulus. A non-functioning cholecystogram was indicative of biliary tract disease. History and clinical findings were non-specific.*

*In Case No. 6, a history of biliary tract disease could not be obtained initially. Perforation of the gallbladder was due to a combination of neoplasm, inflammation and stones.*

## Inflammatory Strictures

Inflammatory strictures cause from 3 to 4 per cent of all cases of acute mechanical obstruction. A cicatrix following an inflammatory process of the appendix or the gallbladder is the most common. Stricture may develop secondary to ulcers—

especially tuberculous ulceration. Bacillary dysentery, typhoid fever and amyloid disease are reported to cause strictures. Regional ileitis is often complicated by severe stenosis.

Post-traumatic strictures sometimes follow a hematoma or partial mesenteric infarction. Strictures are occasionally late sequelae of radiation therapy.

*Case No. 7.*—H. O., a 72-year-old white male, had intermittent abdominal cramping and associated watery diarrhea for several months. He had an appendectomy 37 years previously for appendicitis with perforation. A wound infection and breakdown had required re-suturing. An incisional hernia developed shortly thereafter. This hernia was repaired, but soon recurred.

Complete gastrointestinal tract roentgenograms showed an incomplete obstruction in the distal ileum (Fig. 3). There were three opaque fruit pits in a loop of dilated ileum just proximal to the constricted area (Fig. 4). He remembered swallowing prune pits five or six years before.

Surgery revealed an incarcerated hernia of the abdominal wall which contained the stenosed area in the distal ileum. The foreign bodies were readily palpable through the bowel wall and were freely movable. The stricture was eight inches proximal to the ileocecal valve.

Gross and microscopic examination of the resected ileum showed very dense peritoneal adhesions encircling the bowel. An acute inflammatory reaction was present. The lumen was narrowed to a diameter of 1 cm. and the bowel wall was .5 cm. thick. The fruit pits could not be milked passed the stricture.

Further questioning of the patient disclosed that he had had vague abdominal pain and distress after eating for a number of years. He has been free of symptoms since the removal of the stricture two years ago.*

*Case No. 8.*—R. V., a 32-year-old white male, had a history of chronic ulcerative colitis for 15 years. The disease was in remission. Sigmoidscopy was essentially negative. A barium enema showed a high degree of retrograde obstruction in the descending colon. There was an 8 cm. zone of narrowing just proximal to the stenotic area.

Surgery revealed a very large inflammatory mass involving most of the proximal descending colon. A left hemicolectomy with transverse sigmoidostomy and a double barrelled terminal ileostomy was done.

The gross specimen showed marked thickening of the muscularis at the stricture. There was no ulceration. The pathology findings were acute and chronic non-specific ulcerative colitis with stricture. There was no evidence of neoplasm.

*Comment: In Case No. 7, the opaque fruit pits seen on the survey examination of the abdomen, led to the diagnosis of a chronic stricture in the distal ileum. The fruit pits became opaque after being coated with alkaline mineral salts of phospherous and calcium for over five years.*

*An obstructing stricture of the colon in chronic ulcerative colitis is unusual.*

## Foreign Bodies

An unlimited assortment of foreign bodies have been swallowed. The majority of these will pass spontaneously through the gastrointestinal tract without complications. Anatomical areas of narrowing and flexures of the intestinal tract are natural sites of obstruction and perforation.

Over 45 varieties of food have been reported as causing acute intestinal obstruction. The mechanism is that of obturator obstruction by the bolus of undigested food residue. Citrus fruit fiber, especially from the orange, is a rather common cause of food obstruction following subtotal gastric resection.

Seventy-five per cent of all perforations of the intestine by foreign bodies occur in the ileocecal area. The usual anatomic sites are Meckel's diverticulum, the distal ileum, cecum and the appendix. Fish bones, chicken bones and toothpicks are prone to perforate the bowel. Localized peritonitis, generalized peritonitis and an inflammatory tumor occur with about equal frequency.

Toothpick perforation of the intestine is most commonly diagnosed as appendicitis. The majority of patients with perforation do not remember swallowing a toothpick.

*Case No. 9.*—J. G., a 54-year-old white male, had persistent belching and small stools with diarrhea for three months and had lost 20 pounds during the past six months. Sigmoidoscopy showed a hard, granular, reddened and ulcerated tumor at the rectosigmoid junction. The bowel was very irritable. The clinical impression was infiltrating carcinoma; however, a biopsy of the lesion showed only chronic inflammatory changes. There was partial retrograde obstruction at the rectosigmoid on barium enema examination, which suggested an inflammatory process (Fig. 5).

At surgery there was an inflammed, hard mass in the distal sigmoid colon with extension to the right pelvic wall. A segmental resection of the sigmoid colon with primary anatomosis was done.

Gross study of the resected tissue showed part of a toothpick perforating the bowel wall and a chronic abscess surrounding the tip of the perfora-

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*Appreciation is expressed to Dr. William Rottschaefer of Holland, Michigan, for permission to include Case No. VII.

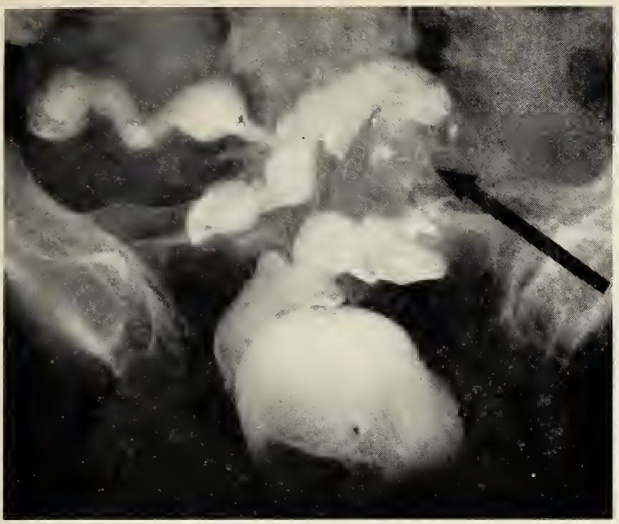

Fig. 5. Partially obstructing inflammatory lesion at the rectosigmoid junction produced by toothpick perforation of the colon.

tion. There was marked induration of the adjacent mesocolon. The other end of the toothpick was in the lumen of the colon.

*Comment: This case is an example of a chronic inflammatory tumor secondary to perforation of the colon by a toothpick. The location of the distal colon is unusual, particularly in the absence of diverticulosis of this segment of the colon.*

## Fecal Obstruction

Fecal impaction caused 5 per cent of the deaths from intestinal obstruction in 1955. Situations contributing to formation of hard fecal masses are: Chronic debilitating disease, senescence, protracted confinement to bed, low residue diet, the postoperative period, pelvic and inflammatory disease and certain types of mental illness.

Obstruction by feces may be by two mechanisms. A single, large, hard, tumor-like fecal ball is probably the most common type. The fecaloma has features of an intraluminal obstruction and may simulate either an obturator mass or a primary neoplasm of the colon.

Another type of obstruction is caused by a long column of inspissated, pasty feces filling the colon and sometimes extending into the small bowel. This variety is likely to develop following treatment of peptic ulcer. The combination of milk, antacids and blood tends to form a thick pasty material. Additional medication consisting of antispasmodics, sedatives and possibly narcotics increases the probability of obstruction.

Obstruction from a fecaloma usually occurs in the rectum, but may be in the sigmoid beyond the reach of the sigmoidscope. Laparotomy may be necessary to establish the correct diagnosis and relieve mechanical obstruction.

*Case No. 10.*—O. R., a 66-year-old white female, was admitted for abdominal distention and a history of no bowel movements for four days. A plain film examination of the abdomen showed moderate distention of bowel. A barium enema the next day revealed complete retrograde obstruction in the proximal sigmoid by a large intraluminal filling defect suggesting a tumor; however, a history of a rather recent negative colon examination cast considerable doubt on this possibility. A cholecystogram five months before was negative. Therefore, by exclusion, obstruction on a benign basis such as fecal impaction or inflammatory disease seemed most likely.

Abdominal surgery showed complete obstruction of the proximal sigmoid by a fecal mass which measured 6 by 7 cm. The colon proximal to the fecaloma was considerably distended. The stool mass was removed through an incision in the sigmoid. No other abnormality was present.

## Summary

A variety of lesions may uncommonly cause obstruction in the intestinal tract. It is advantageous to obtain as much information preoperatively as possible. Often symptoms and clinical findings are nonspecific in regard to the basic pathologic process.

Frequent review of the possible etiologies of intestinal obstruction will aid in diagnosing an uncommon case when it is encountered.

Early barium enema after minimal irrigation is a most helpful procedure and may show characteristic changes of a specific rare condition. The method is applicable to any patient capable of tolerating abdominal surgery.

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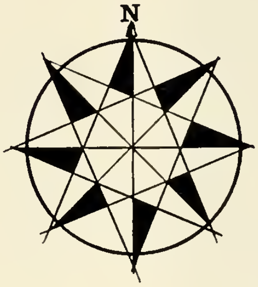
# TUBERCULOSIS



# A WORLD PROBLEM

Among the techniques for combating tuberculosis which warrant development is more intensive activity by the general practitioner, even after he has initially diagnosed the disease. Ontario has initiated such a program. This is one of many challenges facing society throughout the world in endeavoring to cope with the disease. We have just reached the foothills. There are mountains ahead. So says Doctor Wherrett, former president of the International Union Against Tuberculosis in the following condensation of his Baker Lecture: "TB—A World Problem," delivered before the School of Public Health, University of Michigan, under auspices of the Michigan Tuberculosis and Respiratory Disease Association.

**By C. J. WHERRETT, M.D.**

**Canada**

The subject, "Tuberculosis—A World Problem," is one which would have struck a responsive chord in Doctor Baker's heart. Would that we could attack the problem with the same vigor as he did in Michigan so many years ago. Such enthusiasm would hasten the day when tuberculosis is better reported and services organized to diagnose, treat and prevent this serious infectious disease, which takes such a toll in sickness and death in so many countries in the world.

In view of the situation still existing in scores of countries today, we would be well advised to begin consideration of the subject by a quick review of the TB situation as it was in our own country at the beginning of the century, when Doctor Baker instituted the reporting of tuberculosis in Michigan. Such conditions are now confronting health workers in many countries of the world and may confront some of us who find ourselves in high incidence areas.

There was TB on every street and the death rate was approximately 40 times what it is now. Nine out of 10 people believed that TB was hereditary and incurable. There was a widespread conviction that all this talk of germs was nonsense. There were no sanatoria, no diagnostic clinics. Most people were so frightened of TB that they did not go to the doctor when they first became worried, and their families did everything they could to conceal the disease. There was poverty and hardship which, in our present-day prosperity, we find a little hard to comprehend. It was not as easy to be clean in those days as it is now. There was lack of knowledge about diet and deficiency diseases were common.

* * *

WHEN WE FACE tuberculosis as a "world problem," we have to take into account the fact

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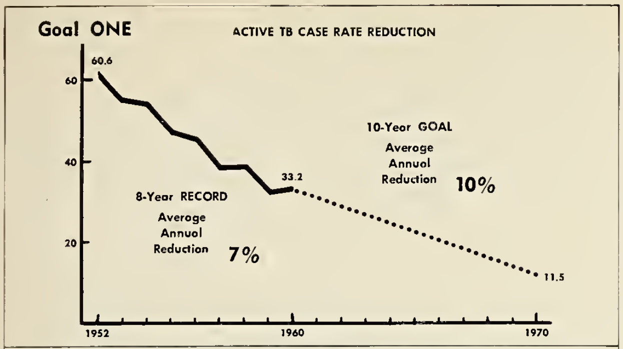
C. J. Wherrett, M.D., presently director of research for the Canadian Tuberculosis Association, formerly was executive secretary of CTA for 29 years and served as president of the International Union Against Tuberculosis (1959-61).



**Goal TWO** A TUBERCULIN REACTOR RATE, in every community, of not more than ONE PER CENT for 14-year-olds

that there are still millions of people suffering from these very same handicaps.

When a person from a country where the tuberculosis death rate is 100 or 200 per 100,000 listens to a speaker from a country where the death rate is less than 4 per 100,000, the listener feels a strong inclination to say to himself, "This man has no idea of our problems." If the speaker is my age, he may not have faced this specific problem, but his generation can remember some fairly grim facts. When I began my career in tuberculosis work, we knew that half the patients we saw on rounds would be dead within five years, no matter what we did. We knew that most of our patients left a trail of infected friends and relatives behind who would be victims in months or years.

This was our youth—yet we have lived to see advances that surpass the most optimistic hopes we ever cherished—and I am certain this will also be the experience of those who work in the areas where rates are quoted by hundreds per hundred thousand and where the rates may be even higher than quoted because many of the patients are not seen or reported.

I am not forgetting that on other continents there are obstacles which we never faced—population pressures, widespread malnutrition, even starvation. Don't think we underestimate or forget these obstacles. We know the enormity of them, but we know, too, that *you* have tested tools of which we could only dream. You have the drugs—and they are miraculous. You have BCG. You have that intangible thing, the spirit of the times. There was a period in the history of Europe when the love of learning and art spread like a beneficent inspiring epidemic. Men's minds leaped forward as they had not for centuries. Europe was never to be the same again. We call that change the *Renaissance.*

I have no idea what future generations will call this phenomenal interest in health, which is like a yeast fermenting in societies all over the world, but I am sure it will be the same landmark in history that the Renaissance was—and will have a profound influence on tuberculosis control and on a host of other public health problems.

## Control and Eradication

I think the best place to begin our analysis of the situation is with an attempt to define the terms we use. Two words which get a lot of use are *control* and *eradication,* and all too many people use them glibly as if they were interchangeable when, of course, they are nothing of the kind.

*Control* has been defined by the World Health Organization as the situation when not more than 1 per cent of school-leavers (at age 16) will react to tuberculin. Such a degree of control has not been reached in any of our Canadian provinces or your United States. True, there are localities which may be approaching this standard, but areas the size of provinces or states are a long way from it. Overall figures for Canada show that 20 to 30 per cent of our population react to tuberculin.

The forecast for the Province of Ontario may bring home the realities. This province has a good tuberculosis program and has had one of the leading programs for 35 years. In recent years a great deal of tuberculin testing has been done and the epidemiologists have made a forecast on the basis of the percentage of reactors in each age group. They have estimated that, in the year 2000, Ontario will have 300,000 positive reactors.

That figure, in a low incidence area, should give some idea of the distances we are from control, and how very much farther we are from eradication, which means getting rid of every last tubercle bacillus. It is not an impossible goal, but it is a staggering one when one considers that there are great areas of the world where, at the present time, the majority of children are infected with tuberculosis germs by the time they are of school age. For this reason, the two terms should not be used interchangeably. Sometimes I fear that by emphasizing *eradication,* we give the impression that we are within striking distance of it, when actually we are a long way even from *control.*

* * *

SOMEHOW WE MUST convince the entire public that victory is not to be taken for granted, that it is equivalent to abandoning a fire because the flames have died down and ignoring the fact that embers are still aglow underneath. As far as tuberculosis is concerned, public health personnel of all disciplines are like the fire department, which does not turn off the water and leave the scene just because the crowd dispersed when the blaze died down. Our business is to keep ourselves and the public aware that tuberculosis control and eradication is still a long way off. For all practical considerations control is the target for the next generation.

I do not want to leave this subject without stating that obtaining control is an urgent matter. Dr. Rene Dubos, a most objective student of epidemics, says that it is of great importance that a push be made now when the curve of the tuberculosis epidemic is at the bottom of the trough in the cycle of the epidemic. In 1960, he said of control, "It is now or never. In 20 years it may be too late."

## After-care and Reactivations

I would like to discuss some current problems which are of concern everywhere. These are troublesome, no matter what control services exist. The first one is the matter of after-care and reactivations.

Studies in your country and mine have shown that reactivations occur more often than expected. As an example, the notification rate for new cases of tuberculosis in Canada was 31.7 per 100,000. On our registers for tuberculosis, it is estimated that there are roughly 200,000 ex-patients who are receiving some degree of followup service. During the same year, 1961, some 1,365 were notified as reactivations. One is horrified to realize that this is a rate of approximately 682 per 100,000, or 20 times the new case rate in the rest of the population.

There is not general recognition of the mathematical fact that we are adding to the pool of ex-patients steadily. New cases in Canada are still counted by thousands, but deaths are now counted by hundreds. What is more, the huge majority of those dying are elderly patients. The ones recovering will need 30 or 40 years of followup. In view of this, should we not be establishing, in co-operation with the health departments, more out-patient clinics in sanatoria and general hospitals as one way of filling the gap in our followup services.

## Treatment Failures

I have mentioned that in Canada we count tuberculosis deaths in the hundreds, where formerly we counted them in thousands. Here in the United States, you count by thousands insteads of tens of thousands. All the same, there are still deaths which mean treatment failures.

Considering the claim we now make for treatment, why are there any deaths from tuberculosis?

Why have we treatment failures in the United States and Canada, where nobody has to be without drugs for financial reasons?

There are still, of course, a diminishing number of patients who were treated when the drugs were first introduced and before it was established that chemotherapy had to be kept up as long as we now find necessary. Their initial treatment was inadequate and not much can be done about that now.

* * *

THEN THERE ARE the patients who will not take drugs regularly unless the physician or nurse is standing over them. Some of them—the alcoholics in particular—leave a sanatorium against medical advice and neglect their drugs completely until they come back ill, or are brought back. The intermittent use of the drugs causes the bacilli to become less vulnerable to the drugs, or even completely resistant. In the latter case the physician is faced with a patient who is in a sanatorium for the second or third time and for whom it might just as well be 1940, because the drugs are ineffective. Second-line drugs or the treatment of 20 years ago may be tried, but it is probably too late for either.

Negligence in taking drugs after discharge has been attributed to a poor relationship between the patients and the medical staff. It is true that the doctor can do much to challenge his patient to follow medical advice, but there will always be stumbling blocks in the way of personalities of patients—prejudices, education, age and previous habits. But it is important that the physician make efforts to improve the doctor-patient relationship. This relationship is more difficult to create today than it was years ago, when the doctor was seeing his patient in his hospital bed almost daily and engaged in the "laying on of hands" through pneumothorax and pneumoperitoneum treatment.

I have hope that a solution to the problem of patients' neglect of their drugs will be found. It may be that we will find drugs even more magical than those we have now—either drugs which would not have to be taken so frequently or taken for such a long period. There is always the chance, too, that as the public understands the problem more completely, patients will of their own volition become more cooperative. They will, I hope, come to the view that taking their drugs is as necessary to them as taking insulin is to the diabetic.

## Drug Resistance

Years ago we had a lot of trouble with people who would not go to a sanatorium when they were

The Author

C. J. WHERRETT, M.D.

infectious because they would not accept free treatment, explaining that they were too independent to take charity. The fact that they were infecting other people seemed not to make any dent on their self-respect. This same selfishness seems to make those who will not take drugs impervious to the fact that they endanger others as well as themselves.

It is some measure of the emergence of the problem created by the negligent ex-patient that we have a designation, "primary drug resistance," to distinguish the patient infected by drug resistant strains of bacilli from "secondary drug resistance," which comes in some patients after a period of treatment.

* * *

SECONDARY RESISTANCE occurs most frequently when a patient takes drugs irregularly. The degree may vary from only slight loss of susceptibility to complete resistance, where the bacillus grows on culture without trace of the drug. The resulting variations are very confusing and make it well nigh impossible to make a sound assessment of reports coming from laboratories in different parts of the world.

Among the great needs, if we are to mount an attack on tuberculosis in the whole world, is a carefully conducted study employing a standardized technique, usable all over the world. This would enable us to determine the true incidence of primary resistance. Repetition of the study at 3 or 5-year intervals would then show us just how great the threat of this type of infection is.

## Role of the GP

While we are discussing the taking of drugs outside of the hospital, let us consider the role of the general practitioner. Despite all our mass surveys, more than half the cases of tuberculosis were, and still are, diagnosed in doctors' offices—but in the routine from then on, the family physican has little part. Once they became accustomed to the change, doctors seemed pleased enough to have it that way.

It is quite plain that the general practitioner could do a great deal more. He could make sure he knew whether or not his patients were tuberculin reactors and, if so, advise periodic chest x-rays. Perhaps in some cases he should be the one to supervise the discharged patient, as long as he is on drugs.

I can well imagine cases where the family physician might be more successful than the clinic in getting the patient to stick to his drugs.

* * *

THERE IS JUST one difficulty. The general practitioners have, in my experience, shown little enthusiasm for this sort of role. I hope that somehow we can revive their interest. During the past year, a program has been initiated in the province of Ontario whereby the general practitioner became a part of the followup service. He is to be notified of the discharge of the patients, to be given all the information on the patient's clinical status, to be asked to give the necessary attention and to submit reports to the case register, and he is to be paid for his services.

## Further Discussion of Tools

Let us discuss further some of the tools we have mentioned and try to assess what each can do for us.

Immunization has done so much for the control of diphtheria, polio, smallpox and whooping cough, that it is natural to hope that immunization can be employed against tuberculosis. Let us therefore consider what BCG has to offer.

It offers a degree of protection to those who have not already been infected. It is not the hard and fast immunization which can be obtained against smallpox, but there are places where it can be enormously helpful.

I think it will be of great use in those countries where infection rates are still very high. If we know that infants are likely to be infected before they are of school age, then I think that in such an area BCG vaccination of infants and tuberculin negative children has great value. As an example, there are thousands of babies in India, China, Africa and the Middle East born into households where friends and relatives are coughing up tubercle bacilli. They would benefit from a vaccination program.

* * *

WHAT WE NEED, of course, is an effective vaccine against tuberculosis which does not alter the reaction of the vaccinated person to tuberculin.

In the meantime, it is generally accepted that non-reactors to tuberculin among close contacts, student nurses, medical students, laboratory workers, as well as armed forces personnel and others who might be subjected to heavy tuberculosis infection, should be vaccinated against tuberculosis, using the presently available BCG vaccine. This includes Indians and Eskimos in our country.

## What About Chemoprophylaxis?

Almost ever since isoniazid was discovered there has been hope that the drugs could be used, not only for treatment of tuberculosis, but for prevention.

No sessions of the recent meeting of the International Union Against Tuberculosis in Rome were better attended than those where the reports were given on chemoprophylaxis trials. The trials have been made in the Arctic, below the equator, in af-

Author Wherrett urges the entry of more researchers in the field of tuberculosis control, and he urges more research work.

fluent societies, in slum districts, in cities, in villages, among former patients and among patients in mental hospitals.

There were thousands of words devoted to the results. I think, however, that I can sum it up briefly. It has been proven that chemoprophylaxis can prevent infection taking place, while it is being used. It is useful in preventing recurrence among former patients in development of active disease, among children exposed to infection and among infected patients being treated for mental illness. But infection and disease can take place when the use of the drug ceases. To the extent that it prevents relapse of former patients, it is useful for prevention. That is something, and perhaps something about which we should do more than we have in the past.

## The Greatest Need—Research

I am convinced that the great hope for the future is the discovery of a better vaccine and a better drug for the prevention and cure of tuberculosis. It is possible that the greatest service we can do for all the world is to carry on research that would bring forward the better weapons I have mentioned.

The very effectiveness of isoniazid, usually called INH, is a constant reminder of the bitter price which has been paid for failure to press on fast enough with research.

The appalling fact is that the drug had been synthesized in 1912 by a German research scientist as an exercise in experimental chemistry.

It was there, waiting—for forty years—before two drug firms systematically testing drugs on mice, discovered its potential within a few months of each other. I think we must all be haunted by the knowledge of the thousands of lives wasted unnecessarily in those years and we cannot help wondering if some other drugs, equally or even more effective, exist now, but lie idle because our research has not gone far enough to find them.

## Lack of Research Workers

Lack of money is far from being the only obstacle to wider research. I doubt if it is even the chief obstacle. If money does not come from one source it may perhaps be begged from another, but if one cannot enlist competent, dedicated research workers, programs flounder because there is no substitute. The chief obstacle is the lack of competent, dedicated research workers with imagination to formulate ideas. Banting was the great example. His chief contribution to the discovery of insulin was the idea.

It is especially important that we enlist young scientists in our cause at this time, because we need to encourage research in so many directions. The microbiologists seem to have taken enormous strides lately and there is renewed interest in all bacteria and I am satisfied that more research should be undertaken on the tubercle bacillus itself.

I have said that there are new developments in the investigation of the bacillus and its effect on the cells of the body. This has given us a glimpse of the possibilities of the future.

* * *

THOUGH THERE are 15 to 20 million infectious cases of tuberculosis in the world, I still believe that some of us will live to see control in fairly large areas. In the long struggle to conquer tuberculosis, we have, perhaps, reached the foothills. There are mountains ahead. We need younger workers—strong, determined and adventurous.

May I repeat the words of your young, brilliant and martyred President:

> *"Now the trumpet summons us again—not as a call to bear arms, though arms we need—not as a call to battle, though embattled we are—but a call to bear the burden of a long twilight struggle, year in and year out, 'rejoicing in hope, patient in tribulation'—a struggle against the common enemies of man: tyranny, poverty, disease and war itself."*

**Every physician invited, and urged, to participate in MSMS "Measles Immunization" effort, beginning March 1 for six weeks. See article on State Society Page**

# "Eldercare" Plan of AMA Supported

## County Societies Carry Educational Effort to Public

Efforts are being continued in Michigan by physicians to urge their congressmen to support the "Eldercare" proposal of the AMA as superior to the Administration's King-Anderson Medicare approach.

Since the February 6-7 special meeting of the AMA House of Delegates, MSMS officials and county society leaders have added their efforts to those of the AMA officers and staff. Special mailings are being made to MSMS members, committee meetings are being held, conferences are being held in the field, and many communications are aimed at the congressmen, opinion makers and the public.

"Eldercare offers better care than medicare" is the slogan for the educational effort. Proponents point out that Eldercare offers more benefits for the elderly and would cost the taxpayers less.

County society officials report that letters-to-the-editor are proving effective along with speakers bureaus, radio and television programs, special newspaper articles, and the distribution of literature.

Physicians in their daily contacts are making good use of the many newspaper articles which question the provisions of the Administration's bill tied to social security and which endorse the AMA approach.

Typical of the fine newspaper support being received by the AMA is the editorial comment in the *Chicago Daily News*, which on February 5, declared that "The AMA, which understands many of these things better than the politicians, deserves a respectful hearing for its forward-looking proposals."

Physicians should continue to stress three major advantages of the AMA approach, prominent in the Herlong-Curtis Bill (H.R. 3737). They are:

1. It would utilize health insurance for complete coverage, rather than just for services other than hospital and nursing-home care, and it would help beneficiaries pay for the whole package.
2. It would spread the cost of the program among all tax-paying Americans, strictly according to their respective abilities to pay.
3. It would waste no tax money on the health care bills of solvent elderly people.

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***Guest Editorial:***

# Urges Physicians to Help Wipe Out Measles

**By JOSEPH STOKES, JR., M.D.**

**Emeritus Professor and Chairman, Pediatrics**
**University of Pennsylvania**

After years of research, medical science has produced at least three vaccines to protect children against measles, a more dangerous disease than even many physicians are aware.

While the medical profession is familiar with the common sequelae of measles—pneumonia, otitis media, and encephalitis—limited reporting has masked the true significance of the frequency and severity of these complications throughout much of the United States.

In Michigan, for instance, statistics are not available on the incidence of encephalitis associated with measles. Yet, it is known that at least one child in every 1,000 reported measles cases will have such a complication.

Many physicians will assume that the majority of children with measles recover without incident. Those who do not, feel they will generally suffer only transitory effects, even from an apparently severe encephalitic experience. This may be false security, since it is not actually known what the long-term after-effects may be. There have been few, if any, follow-up studies into the adulthood of those children who have suffered from measles encephalitis. It has been well documented, however, that many children, apparently recovered from measles encephalitis, nevertheless, have remained partially crippled by a diminution of mental acuity.

Even without complete reporting, the statistical data now available afford us little assurance. The measles mortality rate is higher than that of any other of the childhood infectious diseases. In 1963, for example, there were 408 deaths in a total of 481,530 measles cases actually reported in the United States.

In November, 1964, 10 deaths among 29,458 reported cases.

In contrast, there have been no deaths throughout the state in either year resulting from polio. Michigan health authorities and private physicians have thus proved the effectiveness of a concerted polio immunization campaign. It is now significant to keep in mind that in many urban areas of the United States, deaths from measles frequently have exceeded those from polio even in the years prior to the Salk and Sabin vaccines.

Despite these facts, and the availability and effectiveness of measles vaccines, only about six million children in the United States have been immunized since the Enders live-virus vaccine was made available in March, 1963. There remain at least 20 million children who are susceptible, and

*(Continued on Page 188)*

# PR Seminar March 25 in Grand Rapids

Speaker at the Awards Luncheon at the County Secretary's Public Relations Seminar, March 25, in Grand Rapids will be Sam Sherman, M.D., of California. An authority on medical legislation and MD-DO relationships, Doctor Sherman will discuss "Medicine and Society." He recently was chairman of a special study committee of the California Medical Association on this subject.

Every MSMS member should be represented at this important Seminar by his county society president, president-elect, secretary, PR chairman, legislative chairman, Operation Hometown chairman, editor and executive secretary. All have been invited—and urged—to attend, along with representatives of the Woman's Auxiliary and the Michigan State Medical Assistants Society.

The event will be held at the Pantlind Hotel, with various MSMS committee meetings and workshops woven in as part of the annual event. Many physicians are expected to stay for the Sixth Annual Congress of the Professions, March 26-27.

# Conference April 21 for News Writers

Michigan newspapers and radio and television stations will be invited to send a representative to the MSMS Conference on Medical Writing for the Mass Media, April 21.

The MSMS Council has authorized the one-day workshop to be cosponsored by the MSU School of Journalism, MSU College of Human Medicine and the Michigan Respiratory Disease and Tuberculosis Association.

The conference will be held at the Kellogg Center for Continuing Education on the MSU campus.

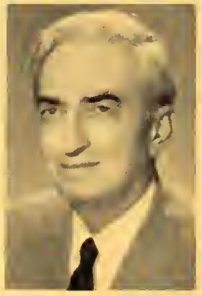
Program details are being completed now.

## Late News

Once again, these four colored pages carry late-breaking news as an added service of Michigan Medicine to the members. A late deadline permits Michigan Medicine to insert these four pages as the journal is being assembled.

# R. R. Cooper, M.D., Joins Council

Cooper



Martmer

Ralph R. Cooper, M.D., Detroit, has taken his seat on the MSMS Council to succeed Edgar E. Martmer, M.D., who has resigned.

Doctor Cooper, a Past President of the Wayne County Medical Society and a Delegate to MSMS House of Delegates, was appointed to the vacancy by The Council. He had been nominated by the WCMS delegates, the procedure followed on filling vacancies.

Doctor Cooper received his M.D. degree from the University of Michigan in 1937. In addition to his practice in Detroit, he serves on the faculty of the Wayne State University School of Medicine.

Doctor Martmer had served on The Council since 1961 and recently was Chairman of The Council's County Societies Committee.

# Dr. Ward Coming

Donovan F. Ward, M.D., President of the AMA, will be the featured speaker for the meeting of the Jackson County Medical Society, March 16.

He then will stay overnight to address the Jackson Rotary Club at noon on March 17.

## Medical Assistants Seminar April 25 Given Endorsement

To Every MSMS Member:

The Michigan State Medical Assistants Society will hold its annual Educational Seminar April 25 at the Michigan Union, Ann Arbor, and every medical assistant—whether a member or not—is cordially invited to attend.

Personally, I am convinced that the excellent program will help the medical assistants be of even greater value to their employers.

Speeches by Kenneth K. Shook, D.D.S., Kalamazoo, on Dental Health Education; by F. Bruce Fralick, M.D., Ann Arbor, on "The Eye in Systemic Disease," and by Reed O. Dingman, M.D., Ann Arbor, on "Modern Concepts of Plastic Surgery" will develop the seminar theme, "New Dimensions for the Medical Assistants."

The deadline for reservations will be April 19.

Sincerely,
G. E. Millard, M.D., *Chairman*
Advisory Committee to MSMAS

## Contain Measles Campaign

*(Continued from Page 187)*

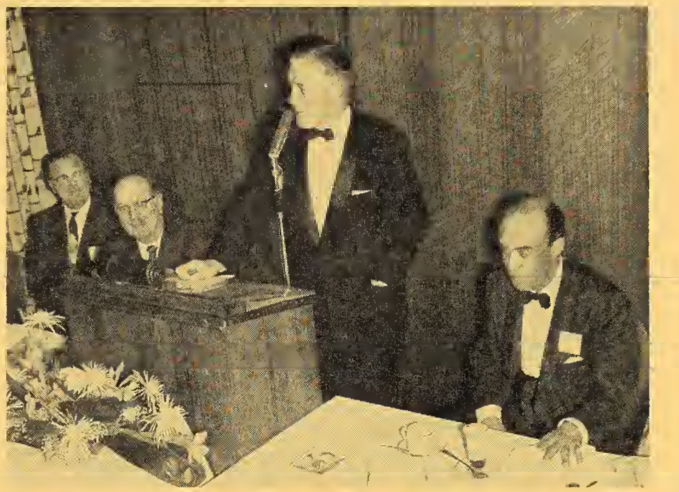
an annual addition of four million infants are born into the susceptible group.

In spite of the attention that may be given to measles in the communications media, the individual parent will seek the advice and follow the instructions of his own family physician or pediatrician. Therefore, it is of great importance that the Michigan State Medical Society launch not only an all-out effort to inform laymen, but also to enlist physicians in a drive for vaccination against measles.

Since the physicians of Michigan have virtually wiped out polio, they should be able to do no less with measles.

(See news article on page 201.)

Wayne County legislators were honored at the annual Legislative Dinner, January 29, at the WCMS building. Special guests from the medical profession included Oliver B. McGillicuddy, M.D., MSMS president, shown seated at the speaker's table. (Michigan Medicine Photos)



Governor Romney addresses the WCMS Legislative Dinner. At far right is State Senator Basil Brown, of Wayne County, majority party floor leader. At left, is F. P. Rhoades, M.D., President-Elect of WCMS; and John G. Slevin, M.D., Chairman of the Public Affairs Committee.

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NEWS BRIEFS:

# *He Who Runs May Read That . . .*

MUSKEGON—An option to purchase a 40-acre site in Muskegon for the location of a new Mental Retardation Treatment Center has been executed. Total purchased price is $120,000, $10,000 of which has been pledged by citizens and organizations of Muskegon. The site is near the Community College development. Total cost of the facility is estimated at $5,000,000. Included in program plans for the 250-bed facility will be both inpatient and outpatient services including: diagnosis, evaluation and consultation services; 90 beds for short-term intensive residential treatment; and 160 beds for long-term residential treatment.

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KALAMAZOO—The Upjohn Company has introduced a new antibiotic, LINCOCIN, to control a spectrum of infections. Harold L. Upjohn, M.D., Medical Director, explains the drug can be administered by injection for a speedy effect and then followed by oral doses for subsequent treatment. He said its unique chemical structure makes it effective against many bacteria which resist other antibiotics.

LANSING—Coordination of mental health services "closer to the home of the patient" will be a major benefit of the new Michigan Community Health program.

So stated Robert A. Kimmich, M.D., state mental health director, at a Mental Health Legislative Conference in Lansing February 3.

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HART—A Speakers Bureau has been established by the Oceana County Medical Society to provide speakers for civic organizations, PTA's and service clubs on medically-related topics.

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CHICAGO—A new record volume of 10,735 medical and health films were lent to physicians, hospitals, medical schools or other professional groups by the American Medical Association Film Library during 1964.

More than 3,000 available motion pictures dealing with every phase of the healing arts are listed in the AMA film catalogue. Copies of the catalogue are available at $5.00 a copy from the AMA.

## No Health Problems Unique to Aging, Says Dr. Swartz

CHICAGO—A point that MSMS and the AMA has consistently made regarding the aging was stressed by Frederick C. Swartz, M.D., Lansing, here at a national conference February 7.

"There are no problems unique to older persons except those posed by retirement and concern for living." So stated Doctor Swartz in an address before a conference on aging, sponsored by the AMA. Doctor Swartz is chairman of the AMA Committee on Aging.

Doctor Swartz stressed that studies show preservation of health among older persons depended not only on medical care but also upon closely-related social, family and vocational factors. He urged that elderly persons requiring long-term medical care be treated according to the dictates of their health rather than their age.

## In Brief:

SHEBOYGAN, WISCONSIN—The Wisconsin-Upper Michigan Society of Ophthalmology and Otolaryngology will hold its spring meeting in Sheboygan, April 3 and 4. Speakers include Brian McCabe, M.D., State University of Iowa, who will discuss diseases of the major salivary glands and the "dizzy patient"; Merle Lawrence, Ph.D., Director of Kresge Hearing Research Institute, University of Michigan Medical School; and Richard O. Schultz, M.D., Marquette University School of Medicine. The two-day program will include an evening session to be held at the Pine Hills Country Club.

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ST. IGNACE—H. E. Hamel, M.D., has been appointed Michigan Week Chairman for Mackinac County. Prentiss M. Brown, Jr., the regional chairman, made the appointment.

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DETROIT—A public program "Poison Is No Picnic" at Cobo Hall, Detroit, March 16, during National Poison Prevention Week, will emphasize the hidden dangers in common household products, pesticides, potent drugs, improper food handling and toxic garden plants.

Principal speakers will include John J. Hanlon, M.D., Public Health Director, Detroit-Wayne County Departments of Health; and Hugo Hullerman, M.D., Administrator, Children's Hospital, Detroit. The Junior League of Detroit and the U. S. Food and Drug Administration, Detroit District, are co-sponsoring this civic program.

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LANSING—The number of Michigan mothers who die from complications of pregnancy could be reduced substantially through good family planning programs, according to a statement made by Herman A. Ziel, Jr., M.D., Health Department obstetrical consultant. Dr. Ziel backed up his statement by citing the record: "According to the Michigan Maternal Mortality Study conducted jointly by the State Health Department and the Maternal Health Committee of the Michigan State Medical Society, about one-fifth of all of the maternal deaths due to obstetrical causes during the period 1960 through 1963 occurred as a result of infection before 20 completed weeks of pregnancy. The study indicated that a majority of these maternal deaths were associated with illegally induced abortion among married women.

"From a public health standpoint," Dr. Ziel said, "Most of these deaths were needless because they could have been prevented by sound family planning."

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CHICAGO—The average Illinois physician, according to a new survey of the Illinois State Medical Society, attends three out-of-town professional meetings annually. In addition, at least one of every two doctors has lectured or had a scientific paper published within the last five years.

The survey also found that the average physician treats an average of 118 patients a week—including 91 in his office, 23 in the hospital and four at home.

## Clarify Ruling on Hospital Accreditations and D.O.'s

*(Editor's Note: Several Michigan physicians have asked for a clarification of an article in a National Medical publication about accreditation of hospitals which allow osteopaths to head one of the medical staff's standing committees. Here is a reply from the AMA on the question.)*

We have your letter seeking to clarify a news statement to the effect that the Joint Commission on Accreditation of Hospitals will no longer withhold accreditation from a hospital which allows an osteopath to head one of the medical staff's standing committees.

I attempted to verify this statement with Mr. James E. Hague, Secretary of the American Hospital Association, who advised me that the AHA's listing requirements have not been revised since 1959 with respect to hospital staff privileges for osteopaths. Although Mr. Hague did not comment directly on the magazine statement, he emphatically denied any change of AHA policy which remains as follows:

"Only doctors of medicine or doctors of osteopathy shall practice in hospitals listed by the American Hospital Association.

"The hospital shall submit evidence of regular care of the patient by the attending physician and of general supervision of the clinical work by doctors of medicine.

"If doctors of osteopathy are practicing in the hospital, then, under the requirements for listing, the overall supervision of clinical work must be under a doctor of medicine (as chief of staff and chief of department, if departmentalized). There is no intention to divorce the attending physician, either M.D. or D.O. from his patient, but the supervision of the clinical activities of all practitioners must be conducted by a doctor of medicine."

I also talked with D. Denver Wickers, M.D., Acting Director of the Joint Commission on Accreditation of Hospitals, who advised me that the Joint Commission has neither adopted nor published any change in the listing requirements of the AHA concerning osteopaths practicing in hospitals.

Stanton S. West,
AMA Department of
Medical Ethics

# MSMS Centennial Series: 1955, 1956

## *Busy Years for Scientific, PR Activities*

*Leading up to the MSMS Centennial in 1965,* The Journal *is printing a series of articles by William J. Stapleton, Jr., M.D., Detroit, who is the MSMS Historian. This series began in the September, 1963, number of* The Journal *and will continue through August, 1965.*

### 1955

One of the highlights of 1955 was when MSMS received the American Trade Association Executives "Grand Award" for all state associations in the United States for the MSMS Medical Associates Program.

Another highlight was the formal organization of the Michigan Foundation for Medical and Health Education to administer loan funds for medical students.

President Baker and Council Chairman William Bromme, M. D., were invited by the AMA Council on Medical Service to speak at a panel in Miami at the AMA Clinical Session, November 29, on implementation of the AMA Program concerning non-service connected disabilities.

A gift from the St. Louis Medical Society of Doctor Beaumont's bed was accepted and placed in the Beaumont Memorial on Mackinac Island.

Karl A. Menninger, M. D., of Topeka, Kansas, was the 1955 Biddle Lecturer.

The Michigan Clinical Institute attendance was 2,980, including 1,786 doctors of medicine.

A conference of Executive Secretaries of County Medical Societies was held at MSMS headquarters, February 15.

The membership for 1954 was 5,239.

* * *

TO FURTHER STIMULATE Medical Public Relations, a MSMS Public Relations Committee member was appointed within each Councilor District to aid the Councilor in promoting the adoption of a well-rounded PR program in the county medical society.

The MSMS Award for "Excellence for Medical Reporting" was given to the *Detroit Free Press,* with a special citation to writer, Jean Pearson, for her continuously high standard in covering Michigan news in the fields of health and medical progress. Other awards went to the *Grand Rapids Herald,* the *Lansing State Journal,* and the *Muskegon Chronicle.*

The First Annual Student Night was inaugurated by the University of Michigan School of Medicine on May 12. The event included papers on various subjects in clinical and experimental medicine. The Annual Student Night was a new educational device in the training of undergraduate medical students.

As soon as the Salk vaccine was proven effective, a tremendous demand for it was created. The public felt that doctors were overcharging. The Michigan Legislature, when passing a bill to provide for the inoculation of indigents, proposed an amendment which would set the fee for the inoculation of indigents. In order to stop this, the MSMS Council set the fee at $2. The Legislature, then was forced to drop its precedent-making amendment.

The Michigan Crippled Children Commission inaugurated a program covering children under the Michigan Afflicted Children Act who were afflicted with rheumatic fever. The medical doctors were paid $3 by the Commission for each injection of bicillin, which was furnished by the Michigan Department of Health.

Michigan Medical Service, as of November 30, had 3,007,391 members. Michigan was first to reach the one-million mark, first to reach the two-million mark, and second to reach the three-million mark.

* * *

THE WOMAN'S AUXILIARY to the MSMS had a very successful year. For the first time, Michigan received a national award for being 100 per cent in the American Medical Education Foundation. Michigan also received a national award this year and a check for outstanding achievement in *Today's Health* subscriptions. The Woman's Auxiliary spent $8,841 for nurse recruitment.

The Author
WILLIAM J. STAPLETON, JR.
M.D.
MSMS Historian

Robert H. Baker, M.D.
MSMS President, 1954-1955

W. S. Jones, M.D.
MSMS President, 1955-56

Twenty-seven counties gave either a loan or a scholarship to nurses.

The 90th Annual Session of the MSMS was held in Grand Rapids on September 28-30. One highlight of the Session was the presentation of the Third Annual Beaumont Memorial Lecture on September 30 by Garret W. Ault, M. D., Washington, D. C.

The Eighth Annual Michigan Rural Health Conference was held at the Kellogg Center on January 20-22, sponsored by the Michigan Foundation for Medical and Health Education and co-sponsored by more than 100 Michigan organizations interested in rural health improvement.

* * *

SO FAR EIGHT COUNTIES had taken advantage of the Medical Examiners law passed by the 1953 Legislature. According to information received by the MSMS, in 1953-54, voters in these counties had acted to replace coroners with M.D. Medical Examiners: Allegan, Hillsdale, Mecosta, Ottawa, St. Joseph, Van Buren, Wayne and Wexford. Oakland, Kent and Genesee counties already had set up the medical examiner system under special legislation adopted prior to the 1953 act.

The Michigan Association of Blood Banks was organized at a meeting at the headquarters of the MSMS in Lansing on June 19. Members of the Blood Bank Committee of the MSMS and of a similar committee of the Michigan Pathological Society met to prepare a consitution.

* * *

## 1956

We asked Doctor Jones what he considered to be his important contributions to the Society during his term of office. He rightly was proud of the development of the Health and Accident Insurance Plan for the members of MSMS.

Here follows a digest of the work of the Society and its Committees for 1956.

The 1955 House of Delegates voted to ask the AMA to appoint a special committee to study the prevention of highway accidents. The House also recommended the principle of state subsidy of student driver training. The Delegates voted to rejuvenate the Committee on Fee Schedules for Governmental Agencies. Resolutions also provided for a special committee to confer with Michigan Medical Service and explored the possibility of a "comprehensive prepaid deductible or coinsurance contract."

The House voted to increase the dues by $10 a year, with $5 towards a new MSMS headquarters.

The Council approved a $6,000 Income Limit Contract of Michigan Medical Service, and a schedule of fees as developed by the MSMS Committee on Fee Schedules for MMS.

* * *

MSMS PRESENTED a plaque to the Medical Exhibitors Association in Detroit, the first time MEA had been honored by any medical society.

Plans were completed to use an IBM electronic system for membership billings in 1957.

The Children's Bureau announced a special grant of $55,000 to help the Michigan Crippled Children Commission treat child amputees from other states. "Michigan is believed to have had more experience in treating children with congenital or accidental amputation than any other state," the Bureau announced.

Michigan Blue Cross-Blue Shield held its 6th annual statewide non-group campaign in September. More than 175,000 persons enrolled under the non-group program in the five years it was offered. It was through this special program that Blue Cross-Shield was able to extend broad coverage on a direct enrollment basis to those who were unable to enroll through the regular employee, farm, or professional groups.

* * *

THE PRESIDENT OF the MSMS was authorized to send a letter of commendation to the Ford Foundation for its financial assistance to approximately 3,500 privately supported hospitals to help them improve and extend their services, to America's privately supported medical schools to help them strengthen their instruction facilities, and to 1,615 regionally equipped, privately supported liberal arts and science colleges and universities in the U. S. to help them raise teachers' salaries.

The 16th Annual Congress on Industrial Health was held in Detroit, sponsored by the Council on Industrial Health of the AMA, the Wayne County Medical Society, the MSMS, the Detroit Society for Surgery of Trauma, the Michigan Industrial Medicine Association, and the Detroit Industrial Physician's Club.

The Michigan Cancer-Coordinating Committee, organized in 1953, justified its existence by stimulating cancer education, both professional and public, and by encouraging each of its component members to further endeavor in a coordinated nonoverlapping program.

Michigan joined in the first nationwide observance of Medical Education Week, April 22-28. With cooperation from the Schools of Medicine of the University of Michigan and the Wayne State University, the MSMS Woman's Auxiliary, and county medical societies, the story of Medical Education Week was told via newspapers, radio, television, movies, and speaking appearances before community organizations.

* * *

THE 1956 UPPER Peninsula Medical Society meeting in Sault Ste. Marie, June 22-23, chalked up a total attendance of 216. The Michigan Medical Assistants Society organized an Upper Peninsula Section, with 44 representatives in attendance.

A Distinguished Citizenship Award was awarded to Howard H. Cummings, M.D., by the Northern Tri-State Medical Association in Ann Arbor.

The fee for Michigan's annual narcotics drug license was raised to $2 by the 1956 Legislature.

The 55th annual meeting of the American Proctological Society was held in Detroit, June 6-9.

## Upjohn Offers Diabetes Drive Info

The Upjohn Company as a public service, is offering a wide variety of new informational materials to medical societies and physicians to help publicize existing diabetes detection drives or to help organize new drives.

County medical societies, local diabetes detection committees, and other interested groups may have sample copies of the descriptive brochure and other promotional literature on request. Write to: Upjohn Company, Office of Trade and Guest Relations, Kalamazoo, Michigan.

## Refers to State Journal

### As 'Portable Bulletin Board'

"Essentially the state journal is the tie that binds. It is the visible thread that runs from one corner of the state to the other. It is the only such ligature. It is an opinion medium for legislative, medicolegal, organizational, economic, and administrative topics. It is the officers' way of reaching the membership; and its is the members' way of letting the officers know what they—the members—think. It is a portable bulletin board for telling the readers what's going one. Without this liaison among members, their esprit-de-corps, their feeling of professional identification, and their sense of organizational identity might well atrophy."—HENRY A. DAVIDSON, M.D. in *Journal of the Medical Society of New Jersey*, 61:1, 1964.

## List Blood Banks Certified in State

The American Association of Blood Banks reports that the number of accredited banks and the scope of the AABB inspection service have reached new records.

"Accreditation means that any patient receiving a transfusion of blood from an AABB-accredited bank can be confident that the bank has voluntarily met the highest scientific standards," reports O. B. Hunter, Jr., M.D., chairman of the accrediting committee. Earnest Booth, M.D., Detroit, is a member of the committee.

A total of 779 community and hospital blood banks have been accredited.

Following is a list of the accredited Michigan blood banks. A code is used as follows:

BB—Blood Bank
Trans. Serv.—Transfusion Service

Bon Secours Hospital Blood Bank, Grosse Pointe
Brent General Hospital BB, Detroit
Burns Clinic Blood Bank, Little Travers Hosp., Petoskey
Butterworth Hospital BB, Grand Rapids
Central Michigan Community Hosp. BB, Mt. Pleasant
Community Hospital BB, Battle Creek
Cottage Hospital of Grosse Pointe BB, Grosse Pointe Farms
Crittenton General Hospital BB, Detroit
Detroit Blood Service, Inc., Detroit
Detroit Memorial Hospital BB, Detroit
Edward W. Sparrow Hospital Trans. Serv., Lansing
Emma L. Bixby Hospital BB, Adrian
Ernie Wallace Memorial BB, Midland
Gratiot Community Blood Bank, Alma
Hackley Hospital BB, Muskegon
Harper Hospital BB, Detroit
Herman Kiefer Hospital BB, Detroit
Highland Park General Hosp. BB, Highland Park
James Decker Munson Hosp. BB, Traverse City
Leila Y. Post Montgomery Hosp. BB, Battle Creek
McLaren General Hosp. BB, Flint
Memorial Hospital BB, St. Joseph
Mercy Hospital BB, Jackson
Mount Carmel Mercy Hospital BB, Detroit
Oakwood Hospital Blood Bank, Dearborn
Pawating Hospital BB, Niles
Pontiac General Hospital BB, Pontiac
Port Huron Hospital BB, Port Huron
Providence Hospital BB, Detroit
Saginaw General Hospital BB, Saginaw
St. John Hospital BB, Detroit
St. Joseph Hospital BB, Mount Clemens
St. Joseph Mercy Hospital BB, Pontiac
St. Lawrence Hospital BB, Lansing
St. Luke's Hospital BB, Saginaw
St. Mary's Hospital BB, Grand Rapids
St. Mary's Hospital BB, Saginaw
Sinai Hospital of Detroit BB, Detroit
Southern Michigan Blood Center, Inc., Detroit
University of Michigan Hosp. Clinical Laboratories BB, Ann Arbor
W. A. Foote Memorial Hosp. Trans. Serv., Jackson
Wayne County General Hospital BB, Eloise
William Beaumont Hospital BB, Royal Oak
Woman's Hospital BB, Detroit

The Doctor's Visit, Jan Steen 1626-1679, Mauritshuis, The Hague

In Diverticulosis and Diverticulitis...

**METAMUCIL®** brand of psyllium hydrophilic mucilloid

"**Diverticulosis** ... a low-roughage diet is advisable.... Constipation is avoided, preferably by the daily use of Metamucil.

"**Diverticulitis** Mild, chronic symptoms of diverticulitis, such as diarrhea or flatulence also are treated[1] by low-roughage diet, adequate fluid intake and Metamucil...."

Usual Adult Dosage: One rounded teaspoonful of Metamucil (or one packet of Instant Mix Metamucil) in a glass of cool liquid one to three times daily.

Metamucil is available as Metamucil powder in containers of 4, 8 and 16 ounces and as flavored Instant Mix Metamucil in cartons containing 16 and 30 single-dose packets.

1. Welch, C. E., Diverticula of the Alimentary Tract, in Conn, H. (editor): Current Therapy—1961, Philadelphia, W. B. Saunders Company, 1961, pp. 224-225.

SEARLE

*Research in the Service of Medicine*

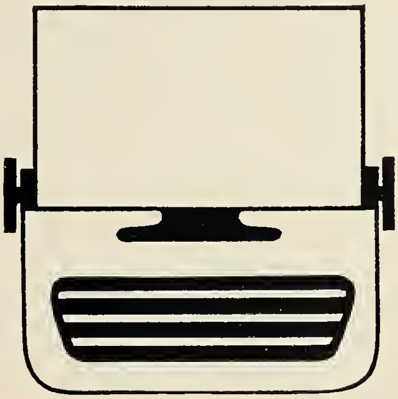
# The Doctor of Medicine and Michigan's Community Mental Health Programs

**By JOHN M. DORSEY, M.D.**
**Detroit**

Ten years ago the State of New York initiated a new era in public welfare in its area of mental health. By legal action it modified the traditional orientation that responsibility for mental health is a problem of state government. Responding to the need for *Legal* local community involvement in certain aspects of the care of psychiatric patients, legislation was established enabling joint state-local community government contributing to the adequate treatment of the citizen's mental health.

Later, other states, e.g., California and Wisconsin, enacted similar legislation. New Yorkers recognized their mental health needs to be vital, extensive and urgent, and their coverage through the structure of government when necessary to be clearly indicated.

For 25 years our Michigan state government has cooperated with local community psychiatric clinics. Now its enabling and permissive legislation has provided a new mechanism for developing and operating more and expanded regional mental health services of several kinds. Michigan's Act 54, 1963, authorized certain local governmental units (a city of 500,000 or more population and any county or combination of counties) to establish mental health programs eligible to receive matching state grants, subject to the Act's provisions and the rules and regulations of the State Department of Mental Health.



**EDITORIAL VIEWS**

The goal is that of establishing a comprehensive network of state-local community service to meet urgent mental disturbance and mental retardation needs and to promote mental health for every citizen. A board, a unit of local government, is to administer and see to the carrying through of its several mental health programs, by a direct or contractual method. To secure federal monies from the state, each program must fit into the whole governmental plan. State grants, subject to a ceiling on a one-dollar-per-capita basis, are made on a yearly span.

* * *

MY PURPOSE is to present some views of possible interest to every M.D. considering, planning for, and carrying out his own continuing home town and county services in terms of these added forces of treatment and prevention.

Wide-ranging federal state and local health proposals claiming both origin in "public demand" and merit as "professional obligation" are critical developments urgently calling for continuing medical research and education. These gradually emerging claims upon every M.D.'s energies seemingly point up his fellow American citizen's cultivation of his health consciousness and civic rights ideals. States Michigan's Mental Health Department Director, Robert A. Kimmich, M.D.:

> "All continuing and expanding program efforts of the Department of Mental

> Health will be directed toward a concept of services congruent with the concepts of decentralized, comprehensive community mental health services which have been proposed at the national level, in order to carry out the spirit of action engendered by the report of the Joint Commission on Mental Health and Mental Illness."

Doctor Kimmich is well aware of the magnitude of his task and willingly able to study and work in terms of such challenging facts as the following.

* * *

THE RATIO OF DOCTORS to population is now 132.7 per 100,000; the rapid developments in scientific knowledge and health services require additional qualified health workers, pressing financial demands in every direction, economic structuring of existing health agencies, and coordination of education and welfare resources; its own "population explosion" is already stretching existing medical school admissions to their limits; the traditional doctor-patient balance is greatly disturbed by the fact that an increasing number of features of medical care are becoming the concern of all manner of personnel; the more the study and practice of medicine *appears* to be "socializable," the heavier and more numerous are the responsibilities of the medical practitioner to treat the compensatory signs and symptoms of this comforting illusion; not only are there too many patients per physician in most areas right now, but also every patient is calling for more treatment over a longer life period (life expectancy has increased from 47 to 70 years in the last 50 years) ; multi-professional new dimensions in health (including hospital) practices ultimately increase every M.D.'s professional responsibilities and associated personal liabilities; the concern for increasing the supply of doctors must be enlightened by such vital considerations as medical competence, adequate distribution of medical manpower, provisions for continuing growth of medical insights and skills, educated use of each medical facility and resource; and overall vigilance must be maintained for the individual patient's responsibility in trying to take care of his own health and learn his most valuable life-lesson of self-help thereby.

Respect for my patient's development of realization of the inclusiveness and the completeness of his individuality does not long remain beyond my mental power as I develop my imaginative capacity for seeing my patient as his own comprehensive self.

Each medical specialty is a by-product of general medical experience. Making up for the choice absence of legal distinction among practicing physicians (beginning with the American Board of Ophthalmology in 1916), specialty boards have proved practical. All specialization has been an off-shoot of medical practice responsibly concerning itself with the whole patient and with the whole physician. It is medical wisdom to be able to see the good of the whole of medicine in each of its apparent divisions. Conversely, the work of the general practitioner, medical or surgical, is of vital interest for every kind of specialist. Dr. Fred B. Rogers observed in his recent A.M.A. article (*Extending the Horizons of Preventive Medicine*), "Every physician should be a general practitioner of preventive medicine, whether a stated specialist or not."

* * *

THE VERY IDEA of "community health services" can be ominously suggestive of a medical project insufficiently founded upon the individual patient, that tried and true base of the study and practice of medicine.

On the other hand, is there anything particularly new about the pattern of local community mental health work? Has not every M.D. always sponsored and spurred this particular health root-orientation by applying himself diligently to the salutary sense in his patient's home, neighborhood, and larger district experience? May there be seen all the more purpose in every M.D.'s now sensing his obligation to stand up for his policies, express his views, and apply his skills in this newly pursued all-out "grass roots" mental health work.

AMA President Donovan F. Ward's recent inspired statement covers the case well: "We just have to keep on telling the story of American medicine, for our story has been a true one." The gist of that story is: unwavering, experienced, responsible concern for the health of the whole human individual.

States the veteran physician, Henry F. Howe (in *The Physician And His Practice*), "Perhaps the most important measure of a man's personal success in a medical career is his degree of success in conducting his own family relations," and, "The richer the store of familiarity with the neighborhood, the better doctor he is. A general refusal of doctors to give their time to community planning can only leave a vacuum of poor planning which eventually boomerangs on the doctors themselves."

* * *

THIS KIND OF medical realism worked up over the centuries by the practicing physician has been gradually becoming the lively understanding of his fellowman. The consequence is that emerging patterns of planning in health education and general welfare now feature the insight that each citizen lives his *local* experiences most intensely and can help himself most practically by means of his specific family and neighborhood opportunities—be what they may, become what they may.

The present generation of the American medical profession is resolutely mobilizing its whole health force to meet the challenge that private enterprise provide leadership for the newly growing mental health interests and functions rapidly springing up both sectionally and nationally. Responsive to the call to implement the National Mental Health Program initiated by President John F. Kennedy, our AMA members officially sponsored their first Mental Health Congress in 1962, and their second one in the fall of 1964.

* * *

OUR MSMS members held their first Dental Health Congress in 1963 and are now planning their second one for 1965.

Well-marked recognition of the integration of the specialty of psychiatry with all of Medicine is always sensible and, particularly now, the course of good judgment. Without the psychological medicine that the general practitioner or family doctor stands for, there would be no medical specialty of psychiatry. Practical application of this organic truth of Medicine, that its wholeness exists in its every part, is fundamental for the safe and sane development of every local community's mental health project.

Although it is impossible to be sure what order will emerge from the presently wide-spread and aroused citizen interest in health affairs, the fact can never be altered that everything having to do with each one's health is entirely his own responsibility.

Every doctor sagely respects his patient's needs for his self-respecting innovations in his self care.

Regardless of the name given to medical treatment, be it "mass medication" or "community health care," the physician's fact remains steadfast; only the given individual *can* get himself sick or get himself well. Every M.D.'s ideal is the preservation of individual life. Appreciation for life contributes chiefly to its preservation. Consciousness for one's own living contributes chiefly to its being appreciated. Everyone's illness or accident summons that one's self-consciousness. To be unimaginative in these respects is to run the risk of being unmedicinal.

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# Symbiosis

**By MRS. MILTON R. WEED,**

**President, Woman's Auxiliary**
**To The Michigan State Medical Society**

The House of Delegates of the Michigan State Medical Society at its 99th Annual Session in Detroit on September 21, 1964, recommended that "a strong plea be made to members of component Medical Societies to encourage membership of spouses" in the Woman's Auxiliary.

Two and one-half months later, the House of Delegates of the American Medical Association at the 18th Clinical Convention in Miami Beach "urged strong support of the Woman's Auxiliary and asked that State and County Medical Societies . . . give serious consideration to joint husband-wife membership."

Why?

Because the leaders in Medicine realize how effective the Auxiliary has become in advancing the aims of Medicine and in winning understanding and friendship *for* the profession and *within* the profession. Doctors' wives are constantly involved in public relations—whether meeting tradespeople, entertaining or participating in community affairs—and, when well informed, they are more effective apologists for medicine than any other group. Auxiliary members project a favorable image of physicians' families through community service, public education, encouragement and support of health careers and by informed political action.

Did you know that the Auxiliary is active in recruiting capable young people into the medical and paramedical fields?

That it conducts educational programs for high school students describing opportunities in medicine, nursing, dietetics, paramedical technology and conducts essay contests to stimulate interest in Medicine?

That it provides scholarship grants to medical students, to nurses, to practical nurses and maintains a loan fund for nurses and medical students?

That, in addition, Michigan Auxiliary members contributed more than $16,000 to AMA-ERF last year?

Did you know that the Auxiliary is active in International Health Activities? That last year it collected more than 10,000 pounds of drug samples for doctors in foreign countries who are striving to achieve our level of medical care? That, in addition, Auxiliary members and their families extend friendship and the warmth of their own fireside to foreign physicians, residents and interns studying in this country?

Did you know that the Auxiliary conducts educational programs in traffic safety, garden safety and poison control? That it organizes and promotes medical self-help training courses for disaster preparedness? That it provides training courses for baby sitters? That its programs encompass mental health and suicide prevention?

Did you know that Auxiliary members have been influential in legislative affairs? That they have a program for instruction in practical basic fundamentals of effective political action at the precinct level? That in last year's "Operation Hometown" one county auxiliary alone assembled and mailed more than 225,000 pamphlets?

And did you know that it has supported the State Society in many other ways from diabetes detection and entertainment to providing furnishings for their headquarters building?

The Auxiliary is a unique organization with unique qualifications for membership. It is unique in its undivided loyalty to the medical profession and in its devotion to improving the health of our citizens. Yet only about one half of eligible physicians' wives belong.

If your wife is not a member, encourage her to join. She will enjoy her social contacts and broaden yours, but more she will become a more effective doctor's wife working on your behalf. Just as you need the Auxiliary's support, the Auxiliary needs your wife's.

## Support Recommended

The laboratory animal has contributed to the salvation of mankind in larger degrees in recent years. The potency, purity, reliability, specificity and safety of many of the major therapeutic weapons available to us has been proven with the help of laboratory animals. The anti-vivisectionists would remove this valiant ally in the fight against disease and ill health.

The National Society for Medical Research is an organization which is involved in education against the anti-vivisection league. It is supported by contributors and welcomes individual donations.

We recommend that every physician consider making such a contribution to support this worthy work.

## Coming in Michigan Medicine in April

*Watch for the April issue of MICHIGAN MEDICINE which will feature an article by Dean William N. Hubbard, Jr., M.D., of the University of Michigan Medical School on the Hippocratic Oath and its historical background.*

*The issue will also feature a major and authoritative paper on Carcinoma In Situ of the Cervix with Genital Tract Extension by Drs. Margulis, Dustin and Daugherty of Detroit. Doctor Seydel from Wayne State University School of Medicine reports on Psoriasis Complicating Radiotherapy, and Drs. Schrader, Marshall, Work and Evans from Ann Arbor describe the use of Spectrophotometric Analysis of Amniotic Fluid in the Management of RH Sensitization.*

**Depend on low-cost, low-dosage Prolixin — once-a-day**

Prolixin is a dependable tranquilizer that provides your patient with low cost therapy. No other tranquilizer costs less. Safe and convenient for office use—Prolixin in a single daily dose provides prolonged and sustained action. Markedly low in toxicity and virtually free from usual sedative effects —Prolixin is indicated for patients who must be alert. Clinical experience indicates fluphenazine hydrochloride is especially effective in controlling the symptoms of anxiety and tension complicating somatic disorders such as premenstrual tension, menopause, or hypertension—also useful for anxiety and tension due to environmental or emotional stress. When you prescribe Prolixin you offer your patient effective tranquilization that is low in cost, low in dosage and low in sedative activity.

THE SQUIBB TRANQUILIZER

WHEN TRANQUILIZATION WITHOUT SEDATION IS DESIRABLE, TRY

PROLIXIN®

SQUIBB FLUPHENAZINE HYDROCHLORIDE

**SIDE EFFECTS, PRECAUTIONS, CONTRAINDICATIONS:** As used for anxiety and tension, side effects are unlikely. Reversible extrapyramidal reactions may develop occasionally. In higher doses for psychotic disorders, patients may experience excessive drowsiness, visual blurring, dizziness, insomnia (rare), allergic skin reactions, nausea, anorexia, salivation, edema, perspiration, dry mouth, polyuria, hypotension. Jaundice has been exceedingly rare. Photo-sensitivity has not been reported. Blood dyscrasias occur with phenothiazines; routine blood counts are recommended. If symptoms of upper respiratory infection occur, discontinue the drug and institute appropriate treatment. Do not use epinephrine for hypotension which may appear in patients on large doses undergoing surgery. Effects of atropine may be potentiated. Do not use with high doses of hypnotics or in patients with subcortical brain damage. Use cautiously in convulsive disorders.

**AVAILABLE:** 1 mg. tablets. Bottles of 50 and 500.

For full information, see your Squibb Product Reference or Product Brief.

SQUIBB Squibb Quality—the Priceless Ingredient

SQUIBB DIVISION Olin

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She lost weight

***a result of**
**'METHEDRINE'® brand**
**METHAMPHETAMINE**
**HYDROCHLORIDE**
**therapy**

Her once unruly appetite is now well tamed with 'Methedrine' (methamphetamine hydrochloride)...an easy way to help control food craving and "hunger pains."

**Side effects:** Insomnia may occur if taken later than 6 hours before retiring. The usual peripheral actions of sympathomimetic amines (vasoconstriction and acceleration of the heart) are minimal and little noticed on low or moderate dosage.

Complete literature available on request from Professional Services Dept. PML.

**Contraindications and precautions:** Should not be used in patients with myocardial degeneration, coronary disease, marked hypertension, hyperthyroidism, insomnia or a sensitivity to ephedrine-like drugs. Moderate hypertension in the obese is not necessarily a contraindication since it may be relieved as the overweight is reduced.

'Methedrine' brand Methamphetamine Hydrochloride: Tablets–5 mg., scored, in bottles of 100 and 1000.

**BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.**

# OUR STATE SOCIETY

## MEDISCENE

**March 11-12**—Maternal & Perinatal Conference, Pick-Durant Hotel, Flint

**March 25**—County Secretaries-PR Seminar, Pantlind Hotel, Grand Rapids

**March 26-27**—Michigan Association of the Professions, Pantlind Hotel, Grand Rapids

**April 14**—Michigan State Medical Society Council meeting, Headquarters, East Lansing

**April 25**—Michigan State Medical Assistants Society Seminar, Michigan Union, Ann Arbor

**May 19**—Wayne State University Alumni Day, Detroit

**June 2**—Michigan State Medical Society Council meeting, Headquarters, East Lansing

**June 10-12**—Michigan Orthopaedic Society, Summer Meeting, Hidden Valley, Gaylord

**July 1**—Annual Claude Keyport Trauma Day, Hidden Valley, Gaylord

**September 16-19**—American Medical Writers Association, Detroit

**September 19-24**—MSMS Centennial Session, Cobo Hall and Sheraton Cadillac Hotel, Detroit

**November 3**—Genesee County Medical Society Diabetes Day, Flint

### TELLS HOW IT IS DONE

"Association Newsletter," a publication of the Association Institute for organizational executives, puts the spotlight on MICHIGAN MEDICINE in its December issue. It states:

"News that breaks after MICHIGAN MEDICINE (Michigan State Medical Society) has been printed is carried in a maize-colored insert called 'Hot News,' which is bound into the center of the magazine. The late deadline for it permits the binder to insert the four pages as the journal is being assembled. Along with featured items, the section covers medical events, community health projects, etc."

## Push Immunization For Measles Effort In State this Month

An extensive public service campaign for immunization against measles is being launched by the MSMS following authorization by The Council at a recent meeting, it was announced by Harold H. Hiscock, M.D., Chairman.

The intensive statewide campaign, to be concentrated during a six-week period starting March 1, is an all-out effort to inform parents of the dangers of measles and to encourage them to consult their physician regarding measles vaccination for their children.

To combat the widespread myth that measles is a harmless disease, the MSMS drive will point up the facts that measles can be a crippler and a killer. Practically every child is susceptible to measles by the time he is nine months old, yet of those who suffer, one in six develops a secondary reaction, and one in 1,000 develops the dreaded encephalitis.

Predicting that this is likely to be another measles epidemic year in Michigan, Doctor Hiscock said, "This is a most important time to stress the fact that measles can be virtually wiped out by use of live-virus vaccine available to physicians."

In stressing the urgent need for immunization, the MSMS will employ every means of communication—the daily and weekly press, radio and TV, billboards and car cards, and professional journals.

Opening with a public educational announcement by Oliver B. McGillicuddy, M.D., President, the MSMS will urge the cooperation of every county medical society.

The subject will be discussed in depth on two television programs produced by the Michigan Association of Professions: "Formula" on WJIM-TV, Lansing, on March 14, and "Decision" on WJBK-TV, Detroit, on April 3.

The MSMS measles campaign is being undertaken as a public service with the cooperation of Merck Sharp & Dohme, which is furnishing press materials and other assistance, free of commercial overtones and without use of its name.

## To Represent MSMS At Rural Health Event

MSMS will be represented by Robert E. Rice, M.D., Greenville, at the 18th National Conference on Rural Health, March 26-27.

The program is developed to explore ways to provide full-range health services for the nation's 60 million rural residents.

Doctor Rice, a MSMS Alternate Delegate to the AMA, is chairman of the MSMS Committee on Rural Medical Service.

# Medicine-Religion Day Sept. 19 to Open Centennial

**(See cover design)**

The Centennial observance of the Michigan State Medical Society, September 19-24, in Detroit, will begin appropriately with a Medicine and Religion Day on Sunday, September 19.

Arrangements have been made to hold a public Medicine and Religion Service in the Ford Auditorium, Detroit, at 3 o'clock that afternoon.

Members of the MSMS House of Delegates will be seated officially at the front of the Auditorium and J. J. Lightbody, M.D., Detroit, Speaker, will call the Centennial Session of the House of Delegates to order.

All interested Detroit area and Michigan residents will be invited to participate in the impressive service, and to observe the opening of the House of Delegates.

Plans for the Sunday program are being advanced by the MSMS Committee on Medicine and Religion. Chairman Richard R. Rapport, M.D., Flint, and his Committee advanced ideas at a Committee meeting held in Detroit, March 1.

* * *

THE SUNDAY AFTERNOON program will highlight an outstanding choir, and a panel presentation by outstanding medical doctors and clergymen.

Rev. Paul McCleave, Director of the AMA Medicine and Religion Program, Chicago, has been secured to serve as Moderator for the panel. Reverend McCleave has indicated this will be the first such major public undertaking in the nation. A similar program was held at Salt Lake City and served as the nucleus for a special AMA Medicine and Religion educational film.

All physicians in the Metropolitan area are urged to attend with their families. Physicians also are urged to alert their own ministers to bring the event to the attention of their church members.

An extensive plan has been developed to send invitations to the full MSMS membership, to physicians in Windsor, to paramedical personnel, to Wayne area ministers, teachers, business and industrial leaders, and others who would be interested.

The master plan for the day includes invitations to radio and television stations to broadcast the event in order to reach many more Michigan residents, and invitations to editors of newspapers and other publications to interpret the event.

The MSMS Medicine and Religion Committee also expects many of the outstate county medical societies to tie in locally with this Sunday, September 19, project in Detroit.

* * *

THE IMPRESSIVE HENRY and Edsel Ford Auditorium provides the ideal setting for such a Medicine and Religion program in the new Detroit Civic Center area. Owned and operated by the City of Detroit, the handsome auditorium provides a seating capacity of 2,926.

There will be no admission charge.

The Medicine and Religion Day will open the MSMS Centennial Session, and will be followed by five other special days.

* * *

FUTURE COVERS OF MICHIGAN MEDICINE will highlight each of the other days, and MICHIGAN MEDICINE will continue to report new developments for the impressive Centennial.

Monday, September 20, will be observed as Medicine and Business, Industry and Communications Day; September 21 as Medicine and Medical Organization Day; September 22 as Medicine and Science Day; September 23 as Medicine and Voluntary Health Day: and September 24 as Medicine and Government Day.

# Dr. Towsley Leads Scientific Program Plans for Centennial

Preliminary plans for the scientific programs at the 1965 MSMS Centennial Session were enthusiastically approved by The MSMS Council, January 27-28.

The Council reviewed the recommendations of the Annual Session Program Committee.

Serving this year on the planning group are H. A. Towsley, M.D., Ann Arbor, chairman with W. C. Baum, M.D., Grand Rapids; Alexander Blain, III, M.D., Detroit; K. H. Johnson, M.D., Lansing; O. B. McGillicuddy, M.D., Lansing; G. Thomas McKean, M.D., Detroit; F. P. Rhoades, M.D., Detroit; J.M. Sheldon, M.D., Ann Arbor; Alan P. Thal, M.D., Detroit, and C. J. Tupper, M.D., Ann Arbor.

## Comments on Challenges In MD-Sports Area

Donald M. Clark, M.D., Medical Director, Phillips Academy, Andover, Mass., made some statements at the Sixth National AMA Conference on the Medical Aspects of Sports which relate to Resolution #13 adopted by the 1964 MSMS House of Delegates.

Doctor Clark emphasized that no category of secondary school is without its problems, and that conditions adverse to good medical care will grow rather than disappear. There are approximately 30,000 secondary schools in the U. S., with a total enrollment of more than 16,000,000 and availability of physicians and qualified trainers or coach-trainers is limited. Few private practitioners can devote the time required of a team physician without reimbursement. Improvement will come only as schools recognize this, said Doctor Clark. In addition, postgraduate teaching seminars on sports injuries, aimed at physicians, physical therapists, trainers, coach-trainers and school nurses, must be expanded.

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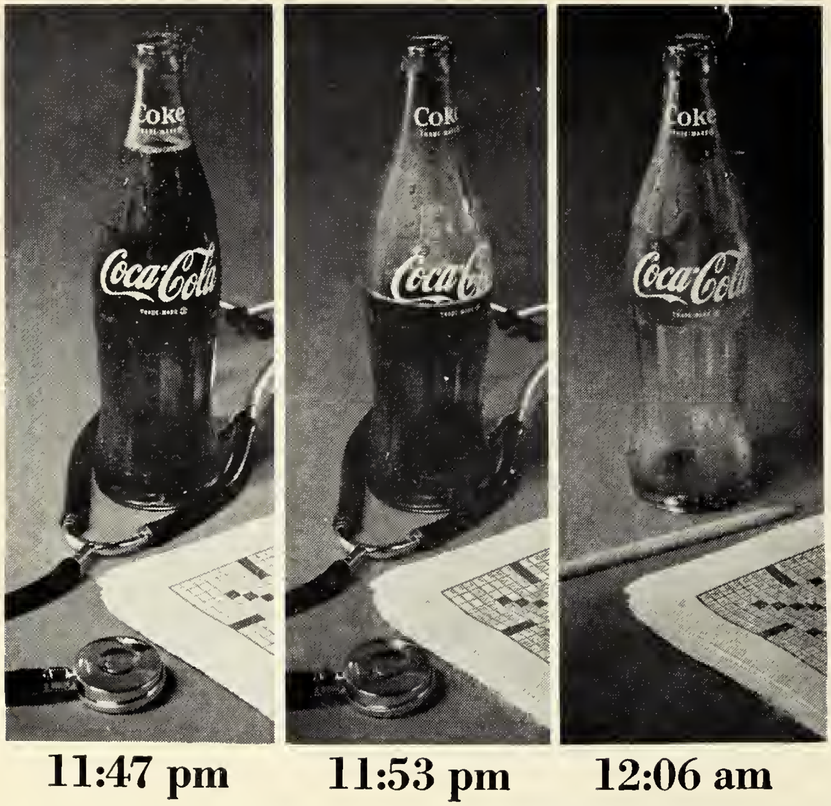

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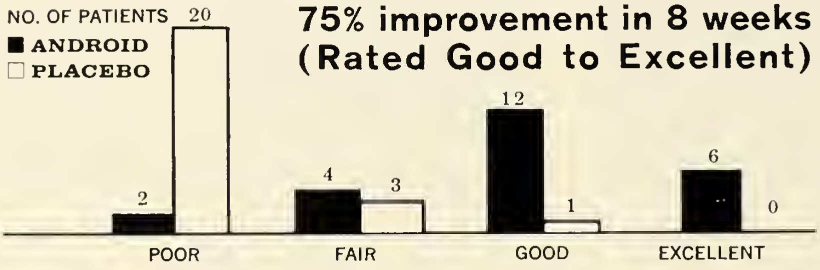

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| Pyridoxine HCl | 5 mg. |
| Niacinamide | 75 mg. |
| Calcium Pantothenate | 10 mg. |
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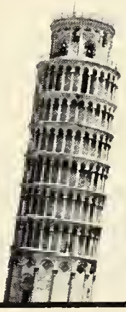
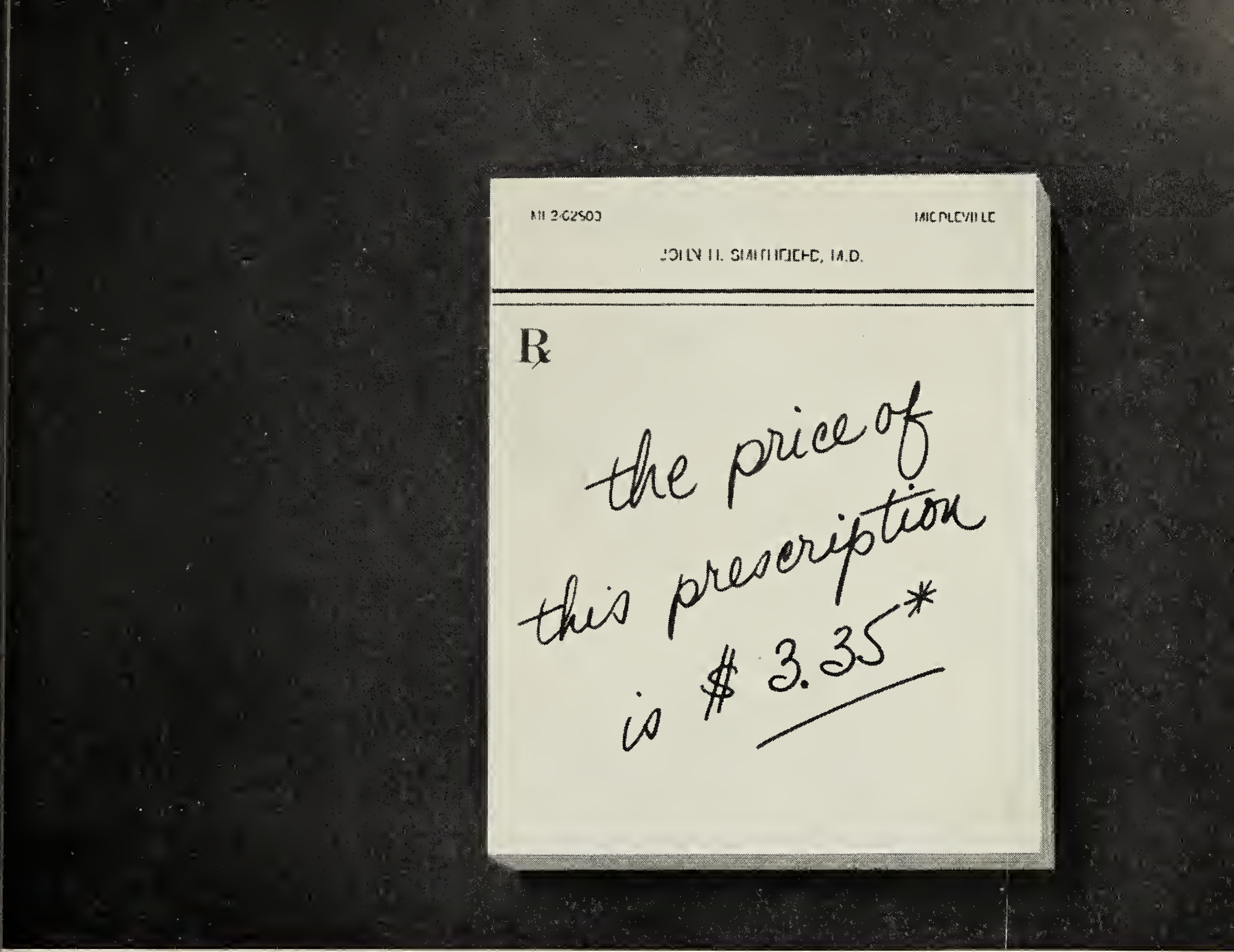
* 1. *Treatment of Impotence with a Methyltestosterone-Thyroid Compound (Android)*, M. H. Dubin, *Western Medicine*, 5:67 Feb. 1964.
2. *Methyltestosterone-Thyroid in Treating Impotence*, A. S. Titeff, *General Practice*, Vol. 25, No. 2, February, 1962, pp. 6-8.
3. *Thyroid-Androgen Relations*, L. Hellman, et al., *The Jrl. of Clin. Endocrinology and Metabolism*, August 1959.
4. Brochure Discussing Thyroid-Androgen Interrelationship.





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# Abstract of MSMS Council Action

## *Meeting of January 27, 1965*

### APPOINTMENT OF COUNCILOR

On nomination of the Wayne County delegation, in accordance with MSMS Bylaws, The Council appointed Ralph R. Cooper, M.D., Detroit, to serve as Councilor of the First District, replacing Edgar E. Martmer, M.D., until the MSMS House of Delegates, at its next Annual Session, shall elect a successor to fill the unexpired term.

### REPORT OF MICHIGAN MEDICAL SERVICE

MMS President Sidney Adler, M.D., reported on merit rating, medicare, and benefit liberalization. At Doctor Adler's suggestion, the Chairman of The Council indicated he would recommend names of one or two physicians who might represent the Michigan State Medical Society at future meetings between Michigan Medical Service and representatives of specialty organizations to discuss new benefit programs adopted by labor and management in the 1964 auto negotiations.

It was also reported that the Joint Commission on Accreditation would be the appropriate source for setting mutually acceptable standards for nursing homes. Presently there is conflict between approval standards acceptable to the American Hospital Association and standards acceptable to the AMA and the American Nursing Home Association.

### APPOINTMENT TO PESTICIDE ADVISORY COMMITTEE

President O. B. McGillicuddy, M.D., reported that he had named George A. Sherman, M.D., Lansing to serve as MSMS representative to a Pesticide Advisory Committee which would jointly serve the State Department of Agriculture and the Pesticide Research Center at Michigan State University.

### QUESTION OF SEPARATE STATE AGENCIES FOR MENTAL HEALTH AND MENTAL RETARDATION

Upon recommendation of the MSMS Mental Health Committee, The Council adopted a policy of opposition to the separation of state government programs for mental health and mental retardation into separate state agencies.

### PROGRESS REPORT ON JUDICIAL COMMISSION

Judicial Commission Chairman Orlen J. Johnson, M.D., outlined in general terms some tentative policies being considered for adoption by the Commission.

### APPOINTMENT OF HOSPITAL FOR CLOSED-CIRCUIT COLOR TELEVISION PROGRAM AT CENTENNIAL SESSION

The Council approved designation of Sinai Hospital, Detroit, as host hospital for the 1965 Centennial Session close-circuit color television program.

### SPECIAL CONVENTION OF AMA HOUSE OF DELEGATES

The MSMS delegates to AMA, meeting in Chicago February 6-7, were authorized to use their best judgment on all matters coming before this special session of the AMA house of Delegates, within the policies established by MSMS.

### RULING OF AMA JUDICIAL COMMISSION

As recommended by The Council and approved by the MSMS House of Delegates, the AMA Judicial Council was requested to render a formal opinion concerning the propriety of physicians using prescription blanks containing printed advertising of a pharmacy or drug store. The Council received the Judicial Council's ruling as follows: "It is unethical for physicians to use prescription blanks with the name of a pharmacy printed thereon."

### LIAISON COMMITTEE WITH THE LEGISLATURE

The Council appointed a liaison committee to meet with bipartisan representatives of each House of the Michigan Legislaure.

### SPONSORSHIP OF DIET THERAPY CONFERENCE

As in previous years, The Council authorized MSMS co-sponsorship of the Michigan Diet Therapy Conference with the Michigan Department of Health.

### CENTENNIAL PROGRAM AND COST ESTIMATES

The Council approved the detailed report and outline of activities and plans for celebration of the MSMS Centennial in September at Cobo Hall.

*(Continued on Page 221)*

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# Ward, Blasingame Speak March 26, 27 At MAP CONGRESS

Both the titular and the administrative heads of the American Medical Association will address the 6th Annual Congress of the Professions at the Pantlind Hotel, Grand Rapids, March 26-27.

Donovan F. Ward, Dubuque, Iowa, AMA President; and F. J. L. Blasingame, M.D., Executive Vice President, will address the main assemblies on Friday and Saturday, respectively.

Oliver B. McGillicuddy, MSMS President, will serve as an Honorary Chairman.

Doctor Ward will be in company with other presidents of national professional associations in a panel treatment of the subject "Relationships Between the Professions and Third Parties," i.e., business, government and labor. Doctor Blasingame will lecture on "Researching the Portfolio of Professional Services."

The 1965 Congress of the Professions will climax "Professional Week" as proclaimed by Governor Romney and the mayors of Michigan cities. During this week, special meetings of professional societies will be held and various community institutions will recognize the contribution made by the professions to human progress.

On the Thursday immediately preceding the Congress and in the same hotel, Michigan State Medical Society will hold its County Secretaries-Public Relations Seminar for the officers of county medical societies and the official family of the State Society.

Gilbert B. Saltonstall, M.D., of Charlevoix, Treasurer of MAP and Senior Medical Trustee on the MAP Board of Directors (other members are Luther L. Leader, M.D., and D. Bruce Wiley, M.D.), reports this Congress would be comparable to previous Congresses each of which has attained nationwide recognition as the "outstanding interprofessional meeting in the nation" due to the caliber of its speakers.

All MSMS members as well as members of the seven other state professional organizations in MAP are invited to attend. Representatives from the professional associations of neighboring states will also be in attendance.

Special visits to the furniture display rooms and museums, plus other exciting events, have been planned for the ladies.

## ANCILLARY SECTION

## AMA Council on Nutrition Pushes Three Objectives

The AMA Council on Foods and Nutrition has approved a new plan of operation "to meet the demand caused by the tremendously and broadly expanding horizon in diagnostic, curative, and preventive medicine."

Its objectives:

1. To disseminate up-to-date nutrition information to the professions and public through articles, pamphlets, books and other means. Two principal means of getting information to doctors is through Council-sponsored articles in the Journal of the American Medical Association, three-to-four day Nutrition and Diet Conferences at AMA meetings, and Council-sponsored symposia where physicians can hear specific nutritional problems discussed by top clinicians and investigators. Fifteen symposia have been sponsored since the initiation of the program in 1955. In preparation is a new reference work: "Nutrition in Clinical Medicine—an AMA Handbook."
2. To publish scientific reports on various classes of foods.
3. To review, on request, educational materials for scientific accuracy.

# Dingman to Address MSMAS on April 25

Reed O. Dingman, M.D., Ann Arbor, has been selected as the L. Fernald Foster Memorial Lecturer for the 8th Annual Educational Seminar of the Michigan State Medical Assistants Society in Ann Arbor, April 25. Doctor Dingman is head of the University of Michigan Plastic Surgery Department.

Among the other major speakers are Bruce Fralick, M.D., Ann Arbor, and Kenneth K. Shook, D.D.S., Kalamazoo.

The MSMAS Seminar will be held at the Michigan Union, under the direction of Mrs. Fae O. Wallace, Ypsilanti, and Doris Schilling, Ann Arbor, co-chairmen.

Reservations may be made with Mrs. Lillian P. Elliott, 402 W. Liberty, Ann Arbor.

The cameraman for WTVS focuses in on the panel for one of the weekly WTVS—Wayne County Medical Society Program "For Doctors Only." This panel is comprised of, left to right, Homer A. Howes, M.D.; Benjamin R. Gutow, M.D., and Abba Terr, M.D.

# WAYNE TV SERIES "FOR MD'S ONLY"

1965 marks the ninth anniversary of the WTVS television program, "For Doctors Only," under the cosponsorship of Wayne County Medical Society and the Wayne State University School of Medicine.

WTVS spokesmen indicated that, according to their information, this is the oldest continuing televised medical series in the country.

The program originated in 1956 as the result of an invitation from WTVS to the Wayne County Medical Society to sponsor a medical program, the purpose of which would be the providing of postgraduate education material for physicians.

Each year approximately 130 M.D. specialists appear on this program. In addition to the Wayne State School of Medicine, the responsibility for specific program presentations is assumed by Wayne County hospital staffs, physician specialty groups, and by volunteer health agencies.

* * *

SINCE ITS INCEPTION the program has been telecast Friday evenings from 8:30 to 9:30 p.m. The first half hour of the program is a formal presentation utilizing a symposium format, consisting of a panel of three or four specialists. During the second 30 minutes of the program, telephoned questions are accepted from physician listeners.

The program is consistently aimed at the physician and those professionals in the para-medical fields. Station personnel, however, indicate that they have reason to believe that the program also appeals to a large lay audience. Approximately 80 per cent of the questions come from physicians, with the remaining 20 per cent from medical students, technologists and the general lay listener. In order to accommodate viewers who find the Friday evening hour inconvenient, the station rebroadcasts the first 30 minutes of the program on Wednesday from 11:30 a.m. to 12 noon.

* * *

POTENTIAL RECEIVERSHIP for the program appears to be unlimited, due to a recent dramatic increase in the number of television sets equipped to receive programs on UHF channels.

Surveys have indicated that the number of sets in Wayne County capable of tuning in Channel 56 have increased from approximately 150,000 in 1961 to well over 350,000 at the beginning of 1965. A recent governmental ruling requiring all new television sets to be equipped with UHF adapters, assures an ever-growing audience for this program.

Nelson Taylor, M.D., Chairman of the Radio and TV Subcommittee of WCMS's Medical Education Committee, states that the ultimate goal will be the utilization of this program by hospitals for their house staffs, and that, hopefully, a two-way communication can be established between hospitals and television station to facilitate the instantaneous receipt of questions from the physician audience.

# Exhibits Available From Health Council

The Michigan Health Council has six exhibits available to help physicians and county medical societies in local educational and public relations activities.

The exhibits can be obtained to use at school career conferences, PTA meetings about child health, child study club sessions on baby emergencies, high school or school programs about smoking and health, etc.

Factual information about the size of the exhibits and a page showing pictures of the six exhibits may be obtained from the Michigan Health Council, Box 431, East Lansing.

## Help Provided for Local Medical Assistant Societies

Leaders of the MSMAS are still hearing complimentary comments about the annual County Officers and Committee Chairman Conference held each year by the Michigan State Medical Assistants Society. Jean Witherspoon of Saginaw was chairman for the program, held in Saginaw.

It was a work session for the county officers and committee chairmen, with a faculty headed by MSMAS President Phyllis Marquardt and other state officers and state chairmen.

The scientific speaker was Silas A. Bradley, Jr., director of Dow Corning Center for Aid to Medical Research, who discussed "Silicones in Medicine and Surgery."

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# HEALTH DEPARTMENT OFFERS GUTHRIE TEST

The Michigan Department of Health is currently making available to hospitals, materials for Phenylketonuria screening of infants, and is performing the Guthrie Test free of charge on request of the hospital administrator with the concurrence of the medical staff.

In April, 1964, the Child Welfare Committee of the Michigan State Medical Society recommended that hospitals in Michigan screen newborn infants for PKU by means of the Guthrie Test. This recommendation was later approved by The MSMS Council.

At the request of physicians, through local health departments, the Michigan Department of Health is providing special synthetic food (low in phenylalanine) for children under medical care for PKU, whose families cannot afford the costly diet low in phenylalanine. When desired by the physician and family, assistance with the dietary management of the child is available from nutritionists on the state or local health department staffs.

Physicans may secure consultation and confirmatory and quantitative laboratory tests for their patients with PKU from Richard Allen, M.D., Director of the Mental Study Unit, University of Michigan Medical Center, Ann Arbor, Michigan. When indicated, a newborn infant suspected of having PKU may be hospitalized for a complete work-up at the Metabolic Research Center, University Hospital, which is sponsored by the United States Public Health Service.

For further information on specific questions regarding PKU, write to Goldie B. Corneliuson, M.D., Director, Division of Maternal and Child Health, Michigan Department of Health, 3500 North Logan, Lansing, Michigan 48914.

* * *

In 1962-1963, ten Michigan hospitals and the Michigan Department of Health participated in a nationwide evaluation of the Guthrie Test, sponsored by the United States Children's Bureau. The test was run on 400,000 newborn infants. A drop of blood was taken from the infant's heel on a special type of filter paper and then tested. The most important result of this trial program is that the "inhibition assay" appears to be a very convenient, sensitive, and reliable screening method for early detection of PKU in the newborn infant, before discharge from the hospital nursery.

The frequency of phenylketonuria among this group of newborn infants was found to be one per 10,347 rather than one in 20,000 as previously stated in the literature. If this incidence of one in 10,000 holds, Michigan can expect that 17 or 18 infants with PKU will be born each year. Institutionalization for life of just one of these children may cost Michigan taxpayers $75,000 to $100,000.

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Bay City, Colonial Rest Home
Berrien Springs, Arcadia Nursing Home
Bloomfield Hills, Weldon Memorial Home
Chesaning, Chesaning Rest Home
Clio, Scott's Nursing Home
Concord, Murray Nursing Home
Detroit, Jefferson Convalescent Home
Detroit, Villa Zion Geriatric Clinic
Elk Rapids, Wilson Memorial Home
Elkton, Wayside Nursing Home
Farmington, Malcolm Palmer Home
Farmington, Pines Convalescent Home
Fenton, Hammond Rest Home
Fenton, Hill Top Acres
Grass Lake, Power's Care Home
Greenville, Graham's Convalescent Home
Highland, Allenwood Cottage Conv. Home
Iron River, Iron River Nursing Home
Jackson, Flint's Nursing Home
Jackson, Hill-Cramer Rest Home
Jackson, Hill Top Rest Home
Jackson, Keeney Nursing Home
Jackson, Northwest Convalescent Home
Jackson, Ryan Convalescent Home
Jackson, Shalom Nursing Home
Jackson, Spalding Nursing Home
Kalkaska, Maple Rest Home
Kawkawlin, La Oda Rest Home
Laingsburg, Van Ever's Nursing Homes
L'Anse, Winkler Nursing Home
Lansing, Beadle Convalescent Home
Lansing, Fairview Convalescent Home
Lansing, Mapleshade Convalescent Home
Lansing, Newcomb Nursing Home
Lansing, Roselawn Convalescent Home
Leslie, Stuart Nursing Home
Lincoln, Lincoln Haven Rest Home
Livonia, Marycrest Manor
Ovid, Ovid Nursing Home
Marne, McClure Nursing Home
Mason, E. R. Lilly Nursing Home
Mason, Holloway Nursing Home
Mason, Robart Nursing Home
Montrose, Montrose Rest Home
Morenci, Morenci Convalescent Home
Niles, Dwellyn Hall
Novi, Novi Convalescent Home
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Pontiac, Oakland Co. Conv. & Rest Home
Pontiac, Pontiac Lake Nursing Home
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Saginaw, McKamie Convalescent Home
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**STATE ASSOCIATION OF LICENSED NURSING HOMES, INC.**

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# Readers Write

H. Herman Young, M.D., editor of the "Yearbook in Orthopedics, Traumatic and Plastic Surgery" has selected my article, "Complete Deltoidectomy for Malignant Tumor," from the October, 1964, issue of Michigan Medicine, to be abstracted for the next Yearbook. Thought you would be interested in this good news.

Sidney C. Walker, M.D.
Port Huron

* * *

As MSMS approaches its Centennial observance, I am sure many members would like to read a fine book, "Saddlebag Doctor," written by William R. Vis, M.D., of Grand Rapids.

It was so interesting to me that I had trouble laying it aside before finishing it. It is unique in that it combines the elements of a novel about the life of a doctor in this community in the early 1800's, essentials of the early history of Western Michigan, and highlights of the history of medicine itself.

The book has earned wide acclaim in Grand Rapids and Western Michigan, and anyone residing in Michigan will find it of great interest. Copies are now in the Clements Library in Ann Arbor, and in the Library of Congress.

Sincerely,
Paul W. Kniskern, M.D.
Grand Rapids

* * *

I want to take this opportunity to thank you and Mr. Auer for the splendid cooperation extended the Michigan Health Council during the past year through MICHIGAN MEDICINE. All of us are very impressed with the Journal and believe that you have certainly come up with the most outstanding state medical society journal in existence.

S. D. Steiner, M.D.
*President*
Michigan Health Council

* * *

The members of the American Medical Association Committee on Nursing wish to call the attention of your MSMS members to a fine article, "Continuing Education in Nursing," which appeared in

the most widely prescribed peripheral vasodilator...

ARLIDIN
(NYLIDRIN HCl)
increases blood flow...

IN CEREBROVASCULAR INSUFFICIENCY
where vascular insufficiency may cause such symptoms as mental confusion, diplopia, fatigue, apathy, and behavior problems.

IN PERIPHERAL VASCULAR DISEASES
where ischemia causes muscle distress—pain, spasm, ache, intermittent claudication; also coldness, numbness or ulceration of extremities.

the November 9, 1964, issue of JAMA.

The members of the Committee are cognizant of the impact of the multitudinous scientific and social advances on nursing practice. They are deeply interested in the variety of programs designed to keep the practicing nurse informed, as well as the many efforts to recruit and re-orient inactive nurses.

They believe that all physicians should not only have a similar awareness, but should also be willing to share in teaching nurses enrolled in continuing and in-service educational programs. Therefore, the Committee on Nursing was pleased to sponsor an article in JAMA which describes a university-centered, continuing education program for nurses and one which might be used as a model by other universities.

Any Michigan physician who would like a copy of the reprint may write me.

Florence M. Alexander, R.N., Ph.D.
*Director,* AMA Department of Nursing

* * *

The six-page article, "Brief Medical Tour in Russia," by Harold A. Furlong, M.D., Pontiac, in your October issue of Michigan Medicine is the best that has ever been published by any of the doctors who have participated on our tours.

I wonder whether it would be possible for us to obtain at least 200 copies so that we may forward them to other members who are contemplating making the same trip in 1965.

Roy F. Leonard
Travel Department
World Medical Association
New York City

(*Editor's Note: The requested reprints were sold at cost to the World Medical Association.*)

## Sees Need to Study Forces

"We are in the midst of a great socio-economic change. We may not like many of the things that are happening, but our dislike will not prevent them from happening. Only by studying the forces causing these changes can we learn how to harness them for the best interest of the profession and the people."

—Wm. S. Apple, *Executive Director*
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## Books Received

MARRIAGE COUNSELING IN MEDICAL PRACTICE. A Symposium. Edited by Ethel M. Nash, M.A., Lucie Jessner, M.D. and D. Wilfred Abse, M.D. University of North Carolina Press, Chapel Hill. Price, $8.00.

MEDICAL ILLUSTRATION—A Guide for the Doctor-Author and Exhibitor. By William E. Loechel, Director, Medical Illustration Department, Wayne State University School of Medicine. Published by Charles C Thomas, Springfield, Illinois.

PREVENTIVE MEDICINE, Volume VII—Communicable Diseases, Arthropodborne Diseases Other Than Malaria. Published under direction of Lt. General Leonard D. Heaton, Surgeon General. Editor-in-chief, Colonel John Boyd Coates, Jr., MC, USA. Available at Superintendent of Documents, Government Printing Office, Washington, D. C. 20402. Price, $4.25.

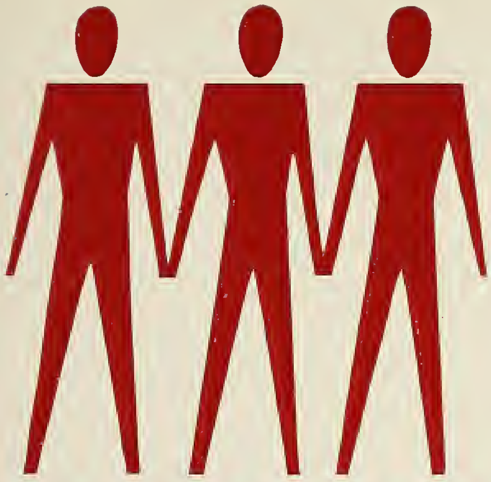
CONSULTATION WITH YOUR DOCTOR FOR PERSONAL UNDERSTANDING OF MARRIAGE. By Jean J. Rutherford, B.A., and Robert N. Rutherford, M.D. Published by Budlong Press Company, 5428 N. Virginia Avenue, Chicago, Illinois 60625.

PEDIATRIC NEUROLOGY. Edited by Thomas W. Farmer, M.D. By 13 authors. Published by Hoeber Medical Division, Harper & Row, publishers, New York 16, New York. Price, $18.50.

BLOOD PROGRAM IN WORLD WAR II. By Brigadier General Douglas B. Kendrick, MC, USA. For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D. C. 20402. Price, $8.00.

Proceedings of the WORLD FORUM ON SYPHILIS and other TREPONEMATOSES by U. S. Department of Health, Education, and Welfare Public Health Service, Communicable Disease Center, Venereal Disease Branch, Atlanta, Georgia 30333. 521 Pages. (Sept. 4-8, 1962) U. S. Government Printing Office, Washington, D. C. 20006. Price $4.00.

CULTURE AND THE DIRECTION OF HUMAN EVOLUTION. A symposium arranged and edited by Stanley M. Garn. Contributors: Albert A. Dahlberg; John W. Crenshaw, Jr.; Harry J. Jerison; Samuel H. Boyer; William Etkin and Theodosius Dobzhansky. Published by Wayne State University Press, Detroit. Price $4.95.



## SOCIO-ECONOMIC

### Slow Rise in Cost Of Living Explained

Living costs in the United States rose less than 5 per cent in the last four years as indicated by the following figures:

| Date | Consumer Price Index | Rise Over Previous year |
|---|---|---|
| December, 1960 | 103.9 | .... |
| December, 1961 | 104.5 | .6% |
| December, 1962 | 105.8 | 1.3% |
| December, 1963 | 107.6 | 1.8% |
| December, 1964 | 107.7 | 1.1% |

The comparative steadiness of living costs for this period is striking when compared to the more than 34 per cent increase which took place during the post World War II inflation era of 1945-48.

Many economists attribute the slow rise in living costs over the last four years to (1) fierce competition for our spending dollar, as competition is a great leveler of prices; (2) general availability of materials and manpower; (3) the vast amount of productive capacity in our country, coupled with huge expenditures for newer and more efficient plants and equipment to cut production costs; (4) a greater disposition on the part of the consumer to spend more of his income on services.

Experts predict that the rise in the cost of living index for 1965 will probably match that of 1964. There is the danger, however, that it will be greater if expected wage increases in the steel industry are passed along in higher steel prices.

## “—IT HAPPENED YESTERDAY, I'M 65”

Yesterday I joined that great group who are for Fedicare (often called Medicare). Yesterday I became 65 years old. Now I have entered that period of life when I am to be cared for by the younger generation simply because I have reached the age of 65, for no other reason on earth than I am now two times 32.5 years old. Before yesterday I was an advocate of the free enterprise system—pay your own way system—don't expect to take anything for nothing system. But all is different now. Now I want (and expect) (haven't I been promised?) 50c per day per ingrown toenail, $30.00 per month for halitosis, 79c per day for ear wax, 18c per day per loose tooth, $7.50 per week plus two quarts of hair tonic for dandruff, 36.5 days of free hospital care per visit (limit 10 visits per year), 31 days of home nursing (young and good-looking nurses) care per month (limit 12 visits per year).

Now so far as drugs are concerned, I expect my blood pressure medicine, tranquilizer, alcohol (for that heart condition—86 proof), aspirin, corn pads and denture adhesive to be paid for by the younger generation—REMEMBER, I'm past 65!

My doctor ($6.00 per office visit) is to be paid for—I am told—by my Uncle who lives in Washington, D. C., and since I think my doctor likes me (and perhaps needs the money) I intend to see him on Mondays, Wednesdays, and Fridays. (I haven't anything else to do and he gets paid on a per patient basis.)

Yes, I'm for Fedicare, Medicare, and just as soon as I finish clipping those damn coupons from a million dollars worth of tax-free municipal bonds, I'm going to start raising Hell for a Medicare program that will include my Lawyer, Tax Consultant, Service Station, Grocer, Tailor, and Undertaker. If Fedicare-Medicare is such a great system for Doctor and Pharmacist why should it be limited to only them? Let's go all the way with the goodness and benefits of the program and give it to all the other professions, businesses, and industries.

Speed the day when Ford Motor Company or General Motors or Chrysler builds me a car *for free* because I'm past 65. Random House and Macmillan must give me free books; *Life, Look* and the *Saturday Evening Post* will come to me without cost and my cemetery lot and a $2,000 tombstone will be charged to the younger generation because I've lived to that magic number—65!

My final comment: God bless all those young folks who have voted to saddle themselves with the debt that will make all these things free to me and mine in our “old” age.

**(signed) I'm 65 yesterday**

(*Editor's Note: Written by M. C. Whitener, M.D., Editor, St. Louis, Mo., County Medical Society Bulletin.*)

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**tranquilization**
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Trancopal "is effective in symptomatic treatment of anxiety."* A powerful tranquilaxant, it also relieves muscle spasm so often accompanying anxiety and tension. Other indications include: ulcer syndrome, spastic colon, alcoholism, premenstrual tension, and bronchial asthma. Side effects such as occasional drowsiness, dizziness, flushing, nausea, depression, weakness and drug rash have been observed in less than 3 per cent of patients. If severe, medication should be discontinued. In most patients, side effects are minor and do not necessitate interruption of treatment. There are no known contraindications. The usual adult dosage is one Caplet® (200 mg.) three or four times daily; in some patients 100 mg. three or four times daily suffice. Dosage for children (5 to 12 years) is usually from 50 to 100 mg. three or four times daily. Trancopal is available in 200 mg. Caplets (green colored, scored) and 100 mg. Caplets (peach colored, scored).

*A.M.A. Council on Drugs: J.A.M.A.183:469 (Feb. 9) 1963.

# Tension complicated by pain?

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# TRANCO-GESIC*

**CHLORMEZANONE** 100 mg. **with ASPIRIN** 300 mg.

TRANCO-GESIC...for the more comprehensive control of pain, especially in tension headache, sciatica, lumbago and musculoskeletal pain associated with strains or sprains...acts dependably and with unsurpassed tolerance. Contraindicated in persons known or suspected to have an idiosyncrasy to aspirin. Side effects such as gastric distress, occasional weakness, sedation or dizziness may be noted occasionally. Ordinarily, these may be reversed by a reduction in dosage or temporary withdrawal of the drug. The usual adult dosage is 2 tablets three or four times daily. The suggested dosage for children from 5 to 12 years is 1 tablet three or four times daily.

*Trademark

Winthrop Laboratories, New York, N. Y. *Winthrop*

## Suggests Ways to Work With Editorial Writers

Four basic suggestions were made at the 1964 AMA Public Relations to County and State Medical Societies interested in fair and favorable newspaper editorials.

Stan Evans, editorial writer for the *Indianapolis News*, pointed out that a newspaper's ledgeable people—is a separate entity functioning independently of the news staff. This staff has its own policies, its own offices and its own line of interests.

Those seeking to receive favorable editorial commentary must establish a working relationship with members of this staff just as they normally do with the news staff.

To cultivate such a relationship, Evans recommended that medical public relations people:

"1. Get to know the people who write editorials. Personalize by calling or visiting them. Let them know what you're doing. Notify them, as well as the city desk, when you plan an event or wish to make a stand of significant community interest.

"2. Know the newspaper's point of view. A newspaper cannot be expected to support positions contrary to its philosophy or past stands. But, by supplying the staff promptly with essential information and facts and by personalizing, you may suggest aspects which have not been considered.

"3. Concentrate on localization. The staff members are flooded with information on the nationwide picture. They are primarily interested in obtaining facts from the local and area viewpoint so they can give specific, localized and personalized interpretations. And, remember, that the purpose of an editorial is to interpret, not to report. Let the staff know of your charitable, humanitarian work. Familiarize it with changes taking place in medicine and what these changes mean to the patient. Explain the purposes of your political programs.

"4. Step up efforts to present medicine's philosophical position. While this position is largely conservative and that of many newspapermen is not, it would be beneficial for medicine to clearly state its case and explain its medical and political stands. Distant hostility is not the answer."

PUBLIC RELATIONS

## TV, Radio Audiences Learn More about Heart

Physicians discussed heart diseases over several radio and television programs during February, according to the sponsoring Michigan Association of the Professions and the Michigan Health Council.

The MAP Decisions program over WJBK-TV featured Park W. Willis, III, M.D., president of the Michigan Heart Association; Thomas F. Richmond, M.D., Cadillac, spoke over the WWTV and WWUP-TV programs; Leo Kenney, M.D., Grand Rapids, over WZZM-TV, and Bert Bullington, M.D., Saginaw, over WNEM-TV.

In another program over WZZM-TV, James H. Beaton, M.D., Grand Rapids, discussed cancer.

---

## SEES OFFICE GIRL AS THE "FRONT DOOR"

*(Following are some excerpts from an address by Wesley W. Hall, M.D., member of the AMA Board of Trustees from Reno, Nevada, to the 1964 AMA Public Relations Seminar.)*

"The 'hostess' in your office—whether she is a nurse, a medical assistant, technician, bookkeeper or all-round Girl Friday—is often responsible for the opinions your patients have of you, and the medical profession as a whole.

"She is the front door to your practice, your ambassador of good will.

"She is the first to greet a patient, and usually the last one he sees. Your patients identify her every word and action—and reaction—with you.

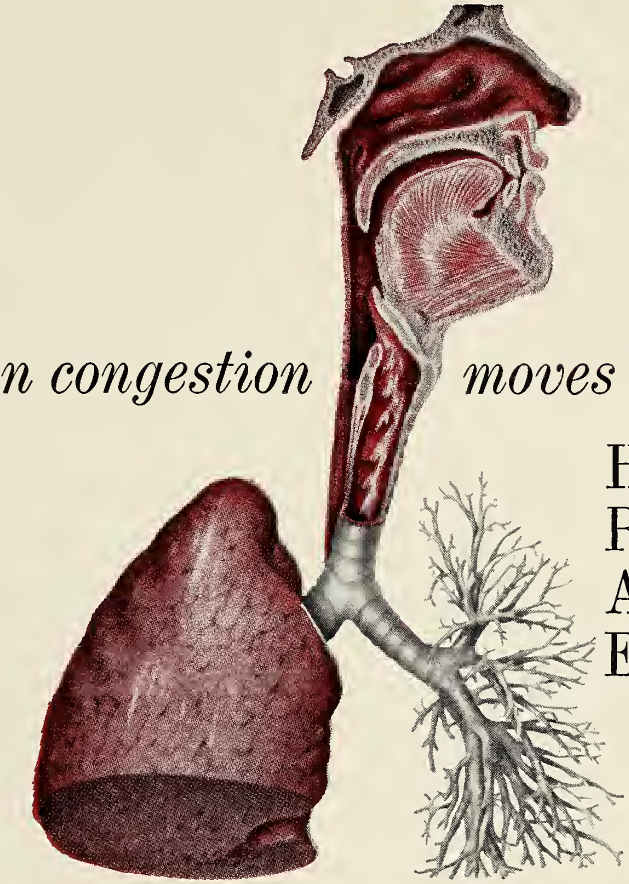
"She can help make or break your practice, whether you realize it or not. If she is courteous, interested in the patients and can keep her mouth shut, she can help you hold old patients and keep the new ones coming back. But if she is sloppy, brusque, impersonal and tactless, she can help drive them away.

"What should you look for when you hire an assistant? A pretty good yardstick is what I call the four A's: Appearance, Ability, Attitude and Actions.

"Several 'helps' are available for your office girl and you.

"May I recommend the AMA pamphlet—'Winning Ways With Patients,' which you can order from the AMA Program Services Department. As a matter of fact, I know of one county society that sent a copy to each doctor's assistant in the area.

"Another way your Girl Friday can learn to be a better assistant is through membership in the American Association of Medical Assistants. This group, through its regular educational programs, the articles in its Bulletin and the certification examination, inspires its members to give honest, loyal and more efficient service both to the profession and to the public."



*when congestion moves down*

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| (Warning: May be habit-forming) | | |
| Homatropine methylbromide | 1.5 mg. | |
| Pyrilamine maleate | | 12.5 mg. |
| Phenylephrine hydrochloride | | 10 mg. |
| Ammonium chloride | | 60 mg. |
| Sodium citrate | | 85 mg. |

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• arrests both productive and nonproductive cough • decongests the airways • liquefies secretions responsible for irritation • provides prompt symptomatic relief of allergic symptoms • is well tolerated • rarely causes constipation

**DOSAGE:** *Average adult dose*—1 teaspoonful after meals and at bedtime with food. *Children 6-12 years,* ½ teaspoonful; *3-6 years,* ¼ teaspoonful; *1-3 years,* 10 drops; *6 months to 1 year,* 5 drops. Administer after meals and at bedtime with food. **On oral Rx where state laws permit.**

**CAUTION:** Should be used with caution in patients with known idiosyncrasies to phenylephrine hydrochloride and in those with moderate or severe hypertension, hyperthyroidism or advanced arteriosclerosis. In these patients the use should not exceed three days. Hycomine* Syrup is generally well tolerated but in some patients drowsiness, dizziness or nausea may occur.

*U. S. Pat. 2,630,400

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# COUNTY SOCIETIES

## Urges County Societies Conduct Orientation for Every New Member

"Membership participation is not a new problem for us; nor is it a problem peculiar to organized medicine. It has, however, reached the near-critical stage within the ranks of the medical profession.

"New physicians are elected to membership, then never attend Society meetings. Outstanding speakers find themselves addressing only a handful of society members. Community projects are planned and promoted, only to fall by the wayside for lack of physician participation. Why?

"Let's take a critical look at the way a new physician is introduced to his medical society. If the formalities are limited to a quick review of the Bylaws, a free meal, and handshake from the President, we've lost another potential leader for organized medicine.

"No matter how small the medical society, a comprehensive indoctrination program for new members is an absolute necessity."

These statements were made by Michael W. McManus, Executive Secretary, Broome County Medical Society, Binghamton, N. Y., at the 1964 AMA Public Relations Seminar.

## Decries Pointed Shoes

Pointed-toed shoes for children, aping the styles effected by their mothers, were decried by the American Academy of Orthopaedic Surgeons, meeting in the Americana Hotel in New York City last week. The Academy took action to "decry the influx of these 'stylized shoes' and urge the shoe industry to carefully review this problem and to redesign this footwear to allow the unencumbered development of the growing foot."

## Chippewa-Mackinac Helps MTU

The Chippewa-Mackinac County Medical Society has presented a check for $1,000 toward the construction of a girls' dormitory at Sault Branch of Michigan Technological University. The University's fund-raising committee expressed appreciation for the "very substantial gift to the project," and pointed out that the money from the society was distinct from the funds pledged also by individual doctors.

## Tri County Meets with DDS's

The Tri County Medical Society joined with the Resort District Dental Society for a recent joint meeting at Traverse City to hear a talk about the Project Hope.

## Kalamazoo Emergency Plan

In the event of serious accident or illness, each school at Kalamazoo has a list of the physicians whose offices are located nearby. These lists are posted in the principal's office and the school health rooms. This project was approved by the Kalamazoo Academy of Medicine as an emergency health care measure, in case the family doctor is located a long distance from the school.

## Oakland Helps Diabetics

A series of five Thursday classes for diabetics and their families was held in Pontiac during January by the Oakland County Medical Society, Oakland County Health Department and several other cooperating organizations.

## Branch Offers Course

Many county medical societies sponsor or cosponsor classes for expectant parents. Such a series was held in January and February in Coldwater with the help of the Branch County Medical Society.

## Hillsdale Allocates $6,000

Two projects "which benefit all county residents" have received $6,000 from the Hillsdale County Medical Society polio vaccine surplus. The Beth Moser Mental Health Clinic was given $4,500 and the local Red Cross Chapter, $1,500.

## Midland Gives Portrait

A portrait of the late Leonard Bergstein, Midland civic leader, has been presented by the Midland County Medical Society to Delta College as a memorial to his work in helping to establish the college.

*(Continued from Page 206)*

## REORGANIZATION OF EXECUTIVE BRANCH OF STATE GOVERNMENT

Upon recommendation of the Legal Affairs Committee, The Council authorized a respectful communication to Governor George Romney, stating that, after considering the Michigan Mental Health Department's program in 1964 as guided by its director, it is the MSMS position that mental health should be designated as one principal department, separate and distinct from other departments.

## STUDY OF DEKARKEY REPORT

The Council requested study of the "President's National Commission on Heart Disease, Cancer and Stroke Reports" (DeKarkey Report) by the Aging Committee, Cancer Control Committee, and Cardiac Disease Control Committee, as it pertains to their interests.

## MEDICINE AND OSTEOPATHY

The Council approved recommendations of the Committee on Medicine and Osteopathy for implementing the specific actions of the 1964 House of Delegates in this matter.

## INTERNATIONAL HEALTH

The Council authorized the MSMS International Health Committee to sponsor a clearing-house for information for Michigan physicians who wish to contribute their time and abilities in international health projects. A questionnaire and an informational sheet on medical health organizations will be sent to all members.

## REHABILITATION FACILITIES SURVEY

The Council received preliminary copies of the MSMS Rehabilitation Committee's Facilities Survey Report, compiled in directory form. A copy of the Rehabilitation Directory will be sent to the secretary of each component medical society. Requests for additional copies should be directed to MSMS headquarters.

## APPOINTMENT TO HOSPITAL RESEARCH AND EDUCATIONAL RESERVE, INC.

MSMS representatives were nominated to the Hospital Research and Educational Reserve as follows: D. Bonta Hiscoe, M.D., Lansing; Hira E. Branch, M.D., Flint; A. Hazen Price, M.D., Detroit; and Frederick S. Gillett, M.D., Grand Rapids. Doctor Branch was designated MSMS representative to the Board of Directors.

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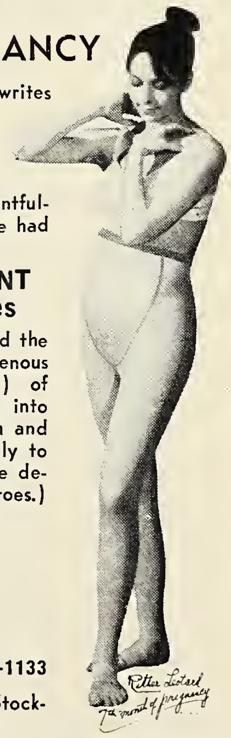

A doctor from Winnipeg, Manitoba, writes of the F. A. Ritter garment custom made for his wife: "We received the elastic garment promptly and my wife has been overjoyed with it. Her pregnancy is continuing uneventfully and in a state of comfort which she had ceased to hope for."

**COMPRESSION TREATMENT of Vascular Insufficiencies**

Years of clinical experience has proved the waist height, custom-made Ritter Venous Pressure Gradient Support (leotard) of great value when varicosities extend into the upper thighs, hips, buttocks, groin and vulva. It is prescribed prophylactically to control these problems after they have developed. (Available with enclosed toes.)

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311 State Street
Grand Rapids, Michigan

## Technique for Catheter Placement for Arterial Infusion

*(Presented by J. F. Baumgardern, Robert J. Lucas, Robert Moffat and Gerald S. Wilson, at a meeting of the Detroit Surgical Association.)*

The easiest and safest way to catheterize an artery for regional infusion with a chemotherapeutic agent is by way of a sufficiently long and expendable branch artery. In instances where there are no easily identifiable branch arteries such as the internal iliac, it was proposed to utilize an autogenous vein graft to produce an artificial branch through which an appropriate catheter can be placed.

In a series of six dogs, a 3 to 4-inch segment of the jugular or splenic vein was anastomosed to one of the iliac arteries through which a silastic catheter was introduced into the artery and tied in place. The animals were re-operated at intervals of one to six weeks, at which time patency of the catheter, vein graft and artery was established, and reaction to the catheter and vein graft was noted. Photographs of the gross and microscopic specimens were taken.

The technique has been used on two patients having recurrent cancer in the area supplied by the internal iliac artery with excellent results.

From these animal experiments and the two clinical cases, we believe this procedure is relatively safe and may well prevent some of the dangers of direct catheterization of the main nutrient artery.

## Michigan Authors

**N. Kazmers, M.D.**, Lakeview, "Meckel's Diverticulum, A Report of 32 Cases," The Journal of the International College of Surgeons, Vol. 42, No. 5, November, 1964.

**Martin J. Urist, M.D.**, South Haven, "Right Angle Exotropia," American Journal of Ophthalmology, December, 1964.

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# IN MEMORIAM

## RUSSELL L. FINCH, M.D.

Russell L. Finch, M.D., 71, former Lansing physician and medical director at Michigan Reformatory and Michigan Training Unit, Ionia, died Friday, January 29, 1965.

A graduate of the University of Michigan Medical School, Doctor Finch came to Lansing in 1929. Doctor Finch had been a prison doctor at Marquette and from 1948 to 1953 was medical director for the state corrections department.

He had held the Ionia post for the last 18 months.

## CHARLES E. LONG, M.D.

Charles E. Long, M.D., 87, Grand Haven's oldest physician, died January 16, 1965.

Doctor Long was graduated in 1906 from the Michigan College of Medicine and Surgery. He practiced in Elk Rapids for seven years before coming to Grand Haven in 1914, where he practiced until his retirement in 1954.

A member of the Grand Haven Board of Education for 17 years, Doctor Long also served as team physician for more than 20 years. In 1952, Doctor Long was honored by the State Selective Service System for giving voluntary service as a medical advisor for more than a decade.

Doctor Long was a Life Member of the Michigan State Medical Society.

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# Reporting as Ordered

### A Monthly Commentary
### By HUGH W. BRENNEMAN, Executive Director

(*Editor's Note: Mr. Brenneman was requested by The Publication Committee and Council to prepare a monthly commentary on activities of MSMS and the headquarters.*)

Two officers of MSMS were re-elected without fanfare at the annual session of The Council, January 27th, 1965. D. Bruce Wiley, M.D., returns as Secretary, William A. Hyland, M.D., as Treasurer. They bring to their positions a combined experience of over 75 years in the official family of organized medicine in Michigan. This is important to the day-to-day workers at headquarters who do the "meat and potatoes" routines. We know we can expect wise, experienced counsel from these men — and that immediately — when the need arises. It's a good feeling.

* * *

*C. J. Tupper, M.D., Scientific Editor of this Journal, Herb Auer, Managing Editor, Warren Tryloff, Associate Executive Director and myself are back for another year, saith The Council. Speaking for myself—and I'm positive for these compatriots too—we have truly enjoyed the curiously challenging nature of our work for you. The reason? You.*

* * *

On a recent wintery Monday, before sand and salt won the day, the parking lot was a slippery sea of slush. It was noteworthy only because the staff members demonstrated a hitherto unknown, but remarkable agility in regaining their balance, revealing inherent acrobatic talent plus a comedy flair for taking classic pratfalls. One pointed out that anyone in organizational work (where walking a tightrope is a daily task) who couldn't remain upright on a little thin ice should be ashamed of himself.

* * *

This headquarters building is truly beautiful and the sign "Michigan State Medical Society" is appropriately dignified. But it is a bit modest. So much so that most people can't read it as they drive by. The Council has suggested a spotlight as the first improvement. Second step may be to accent it with plantings—all efforts directed toward making it a sign instead of a nameplate.

* * *

Community Relations Director Ralph Wills' duties have been reassigned. He is now a roving ambassador traveling around the state personally chatting with the many different medical societies and their officers. His objective—to pass the word on the MSMS plans and projects and in turn find out what the county societies need from the state organization. Present assignment areas to PR Field Secretaries remain the same, but this will not deter Ralph from assisting with the liaison in all sections of the state.

* * *

Bi-monthly staff meetings are not the casual affairs you might think. They are hammer-and-tong sessions that require advance planning and alert thinking on the part of every senior staff member.

The order-of-the day calls for one or more of the staff to prepare a comprehensive work-up on the subject to be taken under discussion and then withstand the ultra-frank discussion of his proposals which emanate from his fellows. The result has been plans for assisting Centennial Committees that have character and appeal, smooth operating major meetings, and an originality and tastefulness in style of action and materials that should be the hallmark of a great profession.

* * *

We were all saddened for our friend Warren Tryloff whose mother died unexpectedly January 29th.

* * *

The MSMS Centennial Session is 8 months away but the final details of its planning are being completed with almost frantic haste. Every staff member realizes the challenge of putting on a once-in-a-lifetime show.

* * *

*Ken Welch, MSMS Assistant Comptroller and membership aide, has the responsibilty for the American flag which flies at headquarters. He reports that the flag has flown at half-staff almost more than full staff during the past year, due to the passing of Kennedy, McArthur, Hoover and Churchill in rapid succession.*

* * *

A button burst off our vest when George Slagle, M.D., past president of MSMS, walking through headquarters said, "This building looks just as good as it did the day we opened it." The truth is, we are not yet using it to capacity. It's like learning to play a violin—we know what it is, how it is played but it takes time to learn how to make it produce music without accompanying squeaks.

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## Delegates

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| J. R. Heidenreich, M.D., Daggett | 1965 |
| W. A. Hyland, M.D., Chairman, Grand Rapids | 1965 |
| O. J. Johnson, M.D., Bay City | 1965 |
| L. R. Leader, M.D., Birmingham | 1965 |
| Sidney Adler, M.D., Detroit | 1966 |
| G. W. Slagle, M.D., Battle Creek | 1966 |
| D. N. Sweeny, Jr., M.D., Detroit | 1966 |

## Alternates

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| W. C. C. Cole, Sr., M.D., Detroit | 1965 |
| G. B. Saltonstall, M.D., Charlevoix | 1965 |
| B. M. Harris, M.D., Ypsilanti | 1965 |
| Otto K. Engelke, M.D., Ann Arbor | 1965 |
| Ralph R. Cooper, M.D., Grosse Pointe | 1966 |
| Oliver B. McGillicuddy, M.D., Lansing | 1966 |
| Robert E. Rice, M.D., Greenville | 1966 |

# MICHIGAN MEDICINE

## the journal of the michigan state medical society

April 1965 • Vol. 64 • No. 4

*More Details about MSMS Centennial Session*
*"The Hippocratic Oath" by Dean Hubbard*
*Calendar of MSMS Spring Postgraduate Program*

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## THEMES SELECTED FOR CENTENNIAL SESSION—SEPT. 19-24, 1965—DETROIT

Sept. 19—Medicine and Religion Day
Sept. 20—Medicine and Business, Industry and Communications Day
Sept. 21—Medicine and Medical Organization Day
Sept. 22—Medicine and Science Day
Sept. 23—Medicine and Voluntary Health Day
Sept. 24—Medicine and Government Day

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*Lennox, W. G.: Epilepsy and Related Disorders, Boston, Little, Brown and Company, 1960, vol. 2, p. 865. 432R65

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**AVAILABLE:** 1 mg. tablets. Bottles of 50 and 500.

For full information, see your Squibb Product Reference or Product Brief.

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**MICHIGAN MEDICINE**

**the journal of the michigan state medical society**

April 1965 · Vol. 64 · No. 4

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Published monthly except two extra issues to be published in October and December, by the Michigan State Medical Society as its official journal at 2642 University Avenue, Saint Paul, Minnesota 55114.

Second class postage paid at Saint Paul, Minnesota.

Yearly subscription rate, $9.00; single copies, 80 cents. Additional postage: Canada, $1.00 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year.

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Printed in USA

## *the president's message . . .*

## Your Medical Society Does Many Things for You . . .

James E. Bryan, the Executive Secretary of the American Medical Writers Association, recently wrote an article in Physicians Management entitled, "What Your Medical Society Can Do for You." I am borrowing liberally from his article for this page.

He pointed out that the benefits are beyond price. I quote a part of his article:

1. "It represents you and your colleagues in public health and welfare programs."
2. "It interprets you—your training, your motives, your problems, your professional aims and objectives to the outside world."
3. "It tries to nurture a more favorable public attitude toward your profession by helping people to understand and appreciate medicine's contribution to the public welfare."
4. "It guides the development of medical practice in relation to other callings and economic groups."
5. "It protects your legal status as a doctor."
6. "It protects the public against exploitation by quacks and frauds and keeps medical competition on a professional plane."
7. "It controls the depredations of that tiny minority of doctors whose main interest is to make a fortune."
8. "It promotes and guides the prepayment plans and other economic devices designed to help patients pay for your services at the least possible burden or sacrifice to themselves."
9. "It helps your profession to meet its collective responsibilities to the public and avoids the necessity of the public resorting to political devices to solve these problems."
10. "It helps you to survive as a responsible professional man in an increasingly interdependent and socialized society."

Mr. Bryan has stated the case well.

*Oliver B. McGillicuddy, M.D.*

---

Afternoon Clinics Added to PG Schedule, Page 265

Second of a series of messages sponsored by The State Association of Licensed Nursing Homes, Inc.

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Lansing, Mapleshade Convalescent Home
Lansing, Newcomb Nursing Home
Lansing, Roselawn Convalescent Home
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Lincoln, Lincoln Haven Rest Home
Livonia, Marycrest Manor
Ovid, Ovid Nursing Home
Marne, McClure Nursing Home
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Mason, Robart Nursing Home
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persensitivity, and most cases of severe renal
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esthesia, 1 week before electroshock therapy,
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*cautions:* Reduce dosage of concomitant anti-
pertensive agents by one-half. Discontinue if
BUN rises or liver dysfunction is aggravated.
ctrolyte imbalance and potassium depletion
y occur; take particular care in cirrhosis or
severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.

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For full details, see the complete prescribing information.

*Average Dosage:* One tablet daily with breakfast.

*Availability:* Bottles of 100 and 1000 tablets.

*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone plus reserpine in moderately severe and severe hypertension: A two year study. Presented at the 7th Inter-American Congress of Cardiology, Montreal, June 14–19, 1964.

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2. Submit original, double-spaced typewritten copy and one carbon copy on letter size (8½ x 11 inch) paper.
3. On page one, include title, authors, degrees, academic titles, and any institutional or other credits.
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8. Articles should ordinarily be less than four printed pages in length (3000 words).
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11. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.
12. It is understood that material is submitted for exclusive publication in Michigan Medicine.

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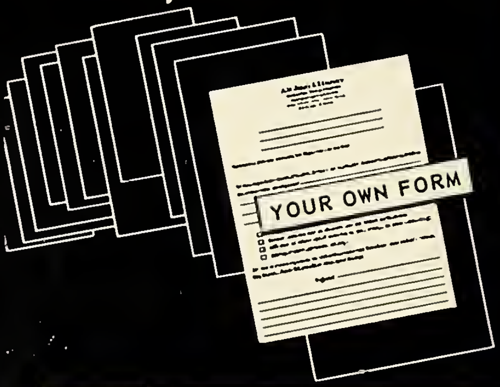

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You might also say that all registered nurses aren't alike, either.

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FAST PAIN RELIEF
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FOR
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# After Surgery: B and C vitamins are therapy

Therapeutic amounts of B and C in stress formula vitamins often are vital during periods of physiologic stress. STRESSCAPS, designed to meet increased metabolic demands, aids in achieving a more comfortable convalescence, a more rapid recovery. After surgery, as in many stress conditions, STRESSCAPS vitamins are therapy.

**Each capsule contains:**

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| Vitamin $B_1$ (Thiamine Mononitrate) | 10 mg. |
| Vitamin $B_2$ (Riboflavin) | 10 mg. |
| Niacinamide | 100 mg. |
| Vitamin C (Ascorbic Acid) | 300 mg. |
| Vitamin $B_6$ (Pyridoxine HCl) | 2 mg. |
| Vitamin $B_{12}$ Crystalline | 4 mcgm. |
| Calcium Pantothenate | 20 mg. |

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7282-4

# in maintenance therapy... a working analgesic for the active arthritic

## ARTHRALGEN®

Each tablet contains:

| | |
|---|---|
| Salicylamide | 250 mg. |
| Acetaminophen | 250 mg. |
| Ascorbic acid (Vitamin C) | 25 mg. |

**a working analgesic for the active arthritic**

—rapidly relieves early morning stiffness and arthritic pain. It promises a quicker response in most patients because its analgesic ingredients need no metabolic conversion before they act. As a combination of two prominent analgesic drugs, Arthralgen can often establish smoother, more complete pain relief because it synergistically produces more efficient analgesia on lower dosage levels of each.

**two proven pain relievers**

Arthralgen combines two better-tolerated, time-tested analgesics, acetaminophen and salicylamide, into a pharmacologically sound and therapeutically effective formulation. As Arthralgen, it penetrates tissues promptly and relieves pain rapidly with less likelihood of gastric irritation than aspirin.

**sodium-free**

Arthralgen contains no sodium. Therefore, it is often a safer and more suitable analgesic for use in the long-term treatments of arthritic patients who have other conditions which require sodium restriction.[1]

## ARTHRALGEN®-PR (Arthralgen with prednisone)

Each tablet contains:

| | |
|---|---|
| Salicylamide | 250 mg. |
| Acetaminophen | 250 mg. |
| Ascorbic acid (Vitamin C) | 25 mg. |
| Prednisone | 1 mg. |

To help provide dosage flexibility in patients who require steroids, the basic Arthralgen formula is also available combined with prednisone as Arthralgen-PR. Prednisone is favored as the more advantageous steroid for use in Arthralgen-PR because it shows less tendency toward sodium retention, potassium excretion, and steroid-induced hypertension than that which often accompanies the use of cortisone and ACTH.[2]

**A. H. ROBINS COMPANY, INCORPORATED/RICHMOND, VIRGINIA**

**BRIEF SUMMARY**

Arthralgen and Arthralgen-PR are indicated in the management of rheumatoid arthritis, acute gouty arthritis, rheumatoid spondylitis, osteoarthritis, bursitis, fibrositis, and neuritis. Arthralgen may be used for analgesia in colds, flu, and various myalgias.

DOSAGE: One or two tablets four times a day. After remission of symptoms dosage should be reduced to the minimum maintenance level.

SIDE EFFECTS: Nausea, GI upset, or mild salicylism may rarely occur. Symptoms of hypercorticoidism dictate reduction of dosage of Arthralgen-PR.

PRECAUTION: Reduction in dosage of Arthralgen-PR given over a long period should be gradual, never abrupt.

CONTRAINDICATIONS: Hypersensitivity to any ingredient.

As with any drug containing prednisone, Arthralgen-PR is contraindicated, or should be administered only with care, to patients with peptic ulcer, tuberculosis, nephritis, diabetes mellitus, acute psychoses, Cushing's syndrome (or Cushing's disease), overwhelming spreading (systemic) infection, or predisposition to thrombophlebitis.

Arthralgen-PR is generally contraindicated in patients with uremia and viral infections, including poliomyelitis, vaccinia, ocular herpes simplex, and fungus infections of the eye. It is also contraindicated in patients with chicken pox or susceptible persons exposed to it.

SUPPLY: Arthralgen (white, scored) and Arthralgen-PR (yellow, scored) tablets are available in bottles of 100 and 500.

REF: 1. Boreus & Sandberg, ACTA. PHYSIOL. SCAND., 28:266, 1953. 2. Cohen, et al.: J.A.M.A., 165:225, 1957.

# **Stelazine®** brand of trifluoperazine
# will calm your anxious working patient—with little or no drowsiness

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Stelazine (trifluoperazine, SK&F) produces a fast therapeutic response—often within 24 to 48 hours. The convenient b.i.d. regimen frees patients from the need for a midday dose.

*Principal side effects,* usually dose-related, may include mild skin reaction, dry mouth, insomnia, fatigue, drowsiness, dizziness, amenorrhea and neuromuscular (extrapyramidal) reactions. Muscular weakness, anorexia, rash, lactation and blurred vision may also be observed. Blood dyscrasias and jaundice have been rare. Use with caution in patients with impaired cardiovascular systems. *Contraindicated* in comatose or greatly depressed states due to CNS depressants and in cases of existing blood dyscrasias, bone marrow depression and pre-existing liver damage.

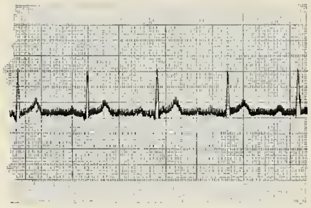
Before prescribing, see SK&F Product Prescribing Information.

Photograph professionally posed.

1. Stoll, L. J.: The Use of Trifluoperazine ['Stelazine'] in General Practice, M. Press 243:578 (June 29) 1960.

SK&F **Smith Kline & French Laboratories, Philadelphia**

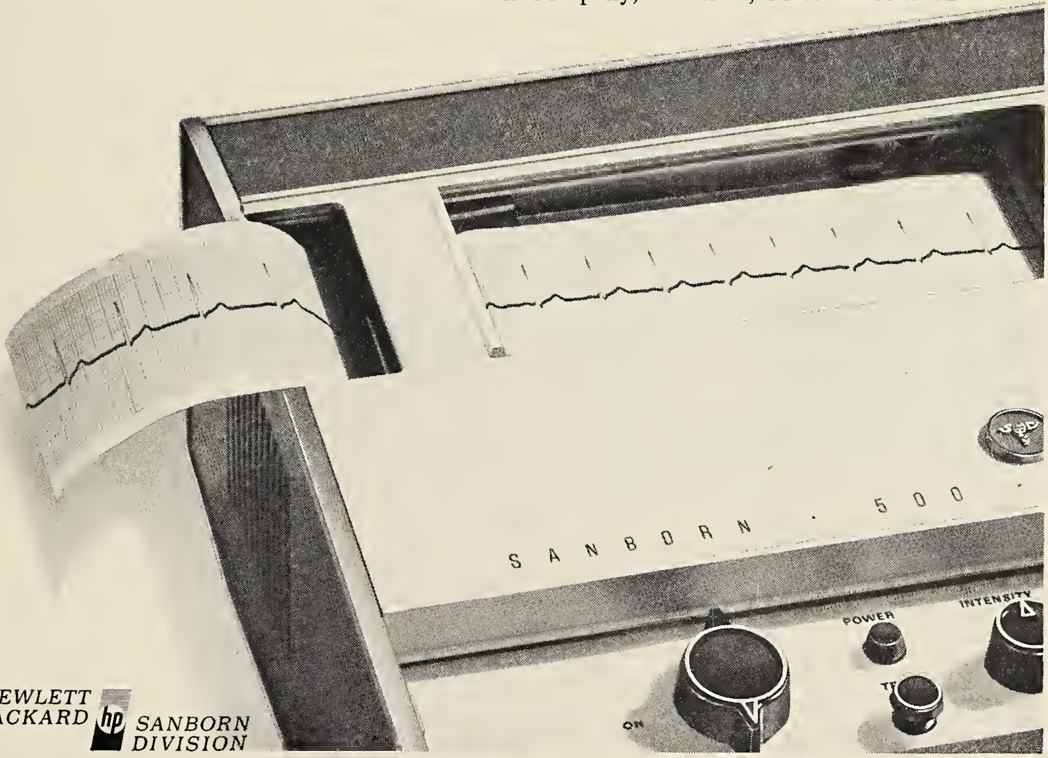
**AC can cause ECG problems**



**the 500 VISO minimizes AC interference**

To help you get *clear,* diagnostically *useful* cardiograms quickly and easily, special circuits in the new 500 VISO effectively cancel the most commonly occurring types of "AC artifacts." And an important companion development which takes advantage of the characteristics of the "500" is Redux *Creme* — easier to apply than an abrasive paste, aesthetically more pleasing to patient and technician alike, less time-consuming from start to finish.

This slim, lightweight cardiograph has two chart speeds, three recording sensitivities, functionally-grouped controls, interior space for all accessories, and other physiologic recording capabilities as well — yet costs only $695 delivered, Continental U. S. Call Sanborn now for full 500 VISO information. Sanborn Company, Waltham, Massachusetts 02154.



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# Medical Research Spending Up 74% in Four Years

Expenditures of medical research in this country amounted to about $1,470 million last year, with an additional $99 million spent by the federal government on new buildings for research according to the Health Information Foundation of the University of Chicago.

About two-thirds of the medical research funds came from government and about one-fourth from the pharmaceutical industry. The remaining one-tenth was from private foundations and other private sources.

Spending for medical research in 1963 was 74 per cent higher than in 1960 and about 1600 per cent higher than in 1947. If this trend continues, it was noted, annual national expenditures may reach $4.4 billion in 1970.

The $161 million expended for medical research in 1950 was about 6 per cent of the total for all research and development. By 1963 it had increased to 8 per cent of the national total.

Between 1947 and 1963, federal expenditures for medical research increased 34 times, from $27 million to $924 million, while expenditures by all other sources increased nine times, from $60 million to $546 million.

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# NEWS BRIEFS

"The Adventures of an Armenian Boy" has been published by **James Kay Sutherland, M.D.**, Flint. Negotiations are under way for commercial publication of the 250-page, well-illustrated book in Britain. The foreword declares the book "is a personal drama, narrated in a folksy, unpretentious manner unveiling petty patterns and strange vicissitudes in the day-to-day fortunes of an Armenian Christian."

Appointed as a new member of the Board of Trustees of the Detroit Institute of Arts is **Irving Burton, M.D.**, Huntington Woods. The Institute recently published "Coins of the Ancient World," written by Doctor Burton.

**Ralph Green, M.D.**, Rochester, is now vice president of the National Association of Private Psychiatric Hospitals.

The American College of Radiology reports that **Walter M. Whitehouse, M.D.**, Ann Arbor, was made a fellow at the ACR annual meeting in Philadelphia.

A new Christian Foundation for Emotional Health has been organized with **Harry Tarpinian, M.D.**, Livonia, as vice-chairman.

**Leslie Corsa, Jr., M.D.**, now chief of the California Bureau of Maternal and Child Health, will begin duties July 1, as director of the new University of Michigan Center for Population Planning.

The keynote address at the annual convention of the Branch County Republicans was **James E. Bailey, Jr., M.D.**, of Coldwater.

**E. I. Carr, M.D.**, Lansing, was one of the panel members on a MSU television program "The Genetic Revolution" with Leroy Augenstein, Ph.D., chairman of the MSU Department of Biophysics and a speaker at the 1964 MSMS Annual Session.

**Ananda S. Prasad, M.D.**, Orchard Lake, will direct research on zinc metabolism in the human, as the recipient of a two-year $14,000 grant to Wayne State University from the Nutrition Foundation.

The new president of the Saginaw Academy of General Practice is **James T. Keyes, M.D.**, and the president-elect is **Neil W. Love, M.D.**

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**Carey P. McCord, M.D.**, Ann Arbor, has received the "Award of Honor" from the American Academy of Occupational Medicine at the annual meeting in Columbus for his "outstanding contributions to the field."

Speakers at the Traverse City Public Forum on Aging, March 23, included **C. Howard Ross, M.D.**, Ann Arbor; **John A. Cowan, M.D.**, Lansing; **LaVerne Wolfgram, M.D.**, and **John T. Ferguson, M.D.**, both of Traverse City.

**H. Marvin Pollard, M.D.**, Ann Arbor, representing the Board of Regents of the American College of Physicians, discussed "Medicine in Yugoslavia" at the recent Pacific Northwest Regional Meeting of the ACP at the University of Washington.

Eleven Michigan pathologists have been certified as Diplomates of the American Board of Pathology. They are **Jose Bebin, M.D.**, Detroit; **Azorides R. Morales, M.D.**, Detroit; **John T. Piligian, M.D.**, Detroit; **John H. Kibeke, M.D.**, Detroit; **John E. Finger, M.D.**, Ann Arbor; **Fred Holtz, M.D.**, Ann Arbor; **Luis E. Owano, M.D.**, Ann Arbor; **Julius M. Ohorodnik, M.D.**, Midland; **Allan H. Russcher, M.D.**, Kalamazoo; **Gene D. Tang, M.D.**, Flint, and **Donald G. Young, M.D.**, Grand Rapids.

The W.S.U. Department of Psychiatry's Wednesday Evening Rotating Lecture Series with **Jacob L. Chason, M.D.**, acting chairman of the Department of Pathology, will continue through April 21.

**Richard Proos, M.D.**, formerly of Otsego, is the new director of Student Health Services at Western Michigan University to succeed the late Edward H. Zwergel, M.D. Doctor Proos, a 1958 graduate of the University of Michigan Medical School, was a general practitioner in Otsego from 1960 to 1964, when he joined the Western Michigan University Health Services.

The speakers at the Detroit Free Press public Heart Forum, co-sponsored with the Michigan Heart Association, included **Park W. Willis, III, M.D.**, Ann Arbor, and **John Sterling Meyer, M.D.**, Detroit.

The Food and Drug Administration has appointed a medical advisory board to help the FDA program for safe and effective use of drugs and the safe use of therapeutic devices. The only Michigan appointee is **Wm. R. Mann, D.D.S.**, Dean of the U-M School of Dentistry.

Medical progress was discussed by **John Manning, M.D.**, and **Dean Ray, M.D.**, at a recent meeting of the AAUW at St. Joseph.

**Stanley M. Beck, Jr., M.D.**, is a new member of the Southgate Community School District Board of Education, appointed to fill a vacancy.

The Cummings Humanitarian Award for "inspired teaching of doctors abroad" has been awarded to **Richard J. Bing, M.D.**, Detroit, by the American College of Cardiology. Doctor Bing delivered lectures in Europe in 1964 as a guest of the ministers of health in Greece, Bulgaria and Czechoslovakia.

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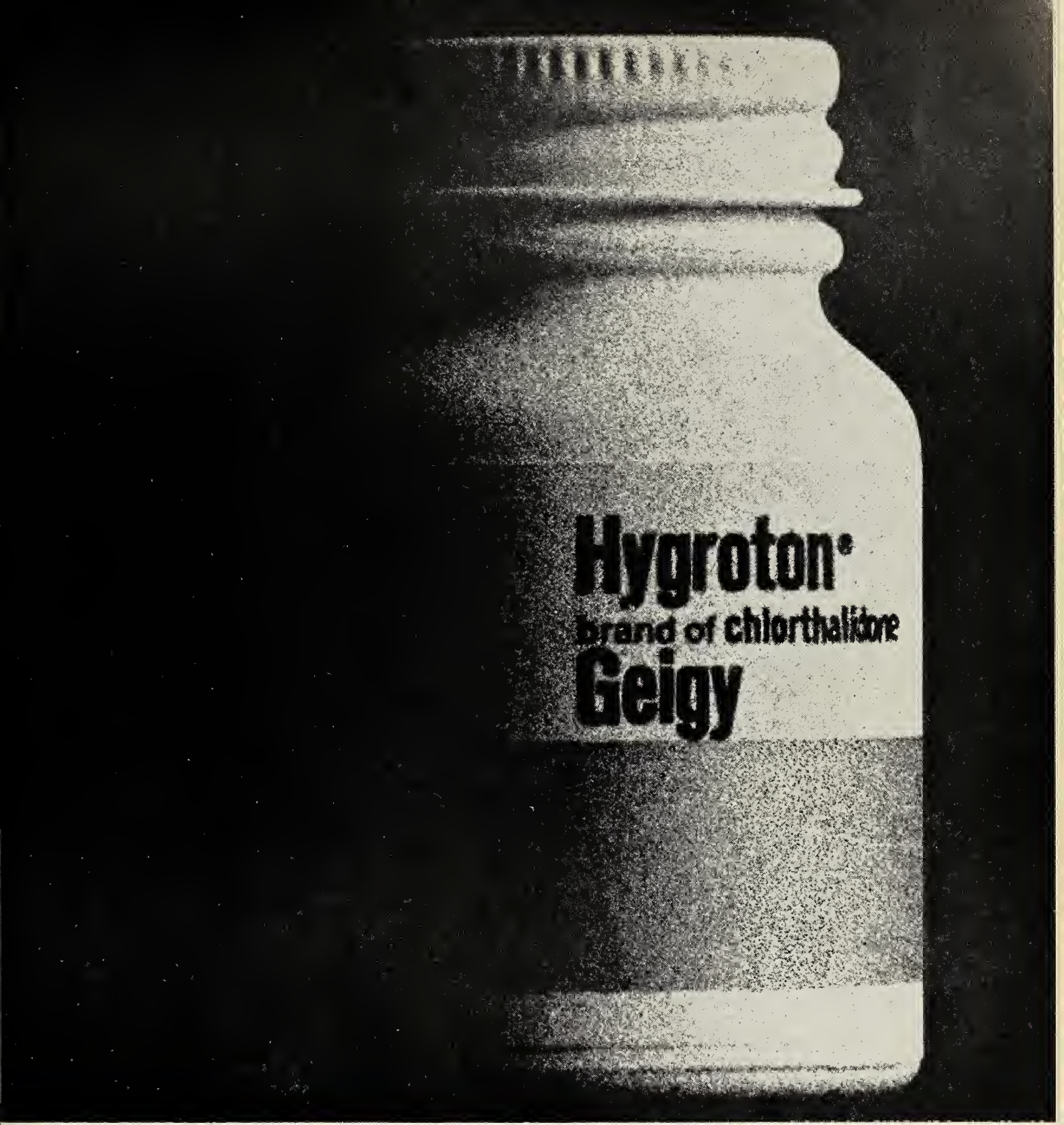

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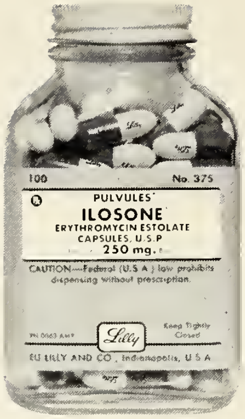
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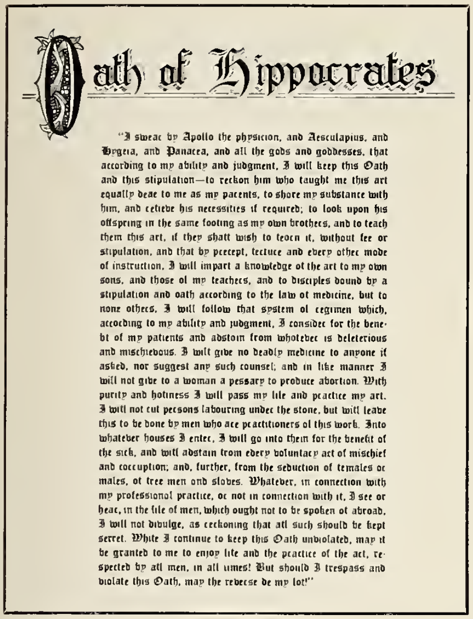

## Oath of Hippocrates

"I swear by Apollo the physician, and Aesculapius, and Hygeia, and Panacea, and all the gods and goddesses, that according to my ability and judgment, I will keep this Oath and this stipulation—to reckon him who taught me this art equally dear to me as my parents, to share my substance with him, and relieve his necessities if required; to look upon his offspring in the same footing as my own brothers, and to teach them this art, if they shall wish to learn it, without fee or stipulation, and that by precept, lecture and every other mode of instruction. I will impart a knowledge of the art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according to the law of medicine, but to none others. I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel; and in like manner I will not give to a woman a pessary to produce abortion. With purity and holiness I will pass my life and practice my art. I will not cut persons labouring under the stone, but will leave this to be done by men who are practitioners of this work. Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption; and, further, from the seduction of females or males, of free men and slaves. Whatever, in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret. While I continue to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men, in all times! But should I trespass and violate this Oath, may the reverse be my lot!"

# The Hippocratic Oath

**By WM. N. HUBBARD, JR., M.D.**

**Ann Arbor**

The Hippocratic Oath is a very ancient set of words, but an even more ancient concept. It is a reflection of the civilization of Greece in its Golden Era.

Hippocrates was a contemporary of Plato—Plato being some years younger—and they were known to each other. Coming from this setting, the Oath is part of the very well-springs of the civilization that we now cherish. It is a part of the history of western civilization. In the dialogues of Plato, the role of the physician was acknowledged as being one of the highest and most explicit expressions of the idealistic social ethic that Socratic philosophy set forth.

One of the characteristics of Greek ethics was that codified statements of their application in practice did not exist. The codification of ethics in categorical laws of morality is a later tradition; coming largely from the scholastic philosophers of the Christian era.

To the ancient Greeks, it was enough to state the ethical principle and then let each man be required to interpret it. Indeed, it was the individual's own self realization within general framework of basic ethical principles that characterized the Greek idea of excellence.

* * *

WITHIN HIPPOCRATIC Medicine there is a tradition, not dissimilar to that of the whole body of learned men of the Greek times, expressing itself in a mood of idealistic motivation. It is in this idealistic tradition that the physician and his later companions in health service are responsible for moving from noble purposes, with a gentle bearing, with faith in humanity and with personal honor.

It was not until the nineteenth century that the Royal College of Physicians felt it necessary to set down more specifically than Hippocrates had in 400 B.C. the regulations that we now call medical professional ethics. Actually, there is now a good deal of confusion between medical ethics and medical etiquette. Percival, in England in 1803, was charged for the first time with writing down a set of standards for professional behavior in one of the London Hospitals. Through some unexplainable misfortune, this set of statements of professional etiquette was published under the title of

**SCIENTIFIC PAPERS**

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Doctor Hubbard is Dean and Professor of Internal Medicine, The University of Michigan Medical School, Ann Arbor.

"Medical Ethics," and since 1803, etiquette and ethics in medicine have been confused.

The physician and all those with clinical responsibility must deal with two very broad ethical systems; one is that of hedonism which regards individual self realization as paramount, and the other is a system based on external idealism which sets outside of the individual an idea or ideal toward which he strives. One cannot distinguish intrinsic good or inevitable evil in either of these ethical systems; but they do not coincide as happy companions.

Let us then consider professional responsibility in the terms of ethical systems. The relationship of one professional to another is typically hedonistic since it is based on a concern with preserving one's role as a specialist. This is not to be decried. The hedonists are the explorers and the rebels; they are the poets; they are the creators. However, they realize their fulfillment out of concern with themselves. It is this hedonist ethic that typically describes the relationship of one professional group to another.

* * *

A GREAT CONTRIBUTION of Greek civilization and the lasting heritage of Plato's philosophy is the addition of idealism, the antidote of Hubris, as a balancing and necessary coexisting ethic with hedonism. It is the idealistic ethic that requires the learned professional to consider the consequences of his conduct quite apart from his own posture but for his patient and for society. It is the idealistic ethic that forces the physician to be concerned with the motive behind his conduct, and to judge the appropriateness of his conduct by this motive as well as by the explicit behavior itself.

I lay some emphasis on this dual system of ethics because the hedonistic and the idealistic philosophies are inherently in conflict with each other. It is important that one recognize that there is an abundant opportunity in the so-called professional ethics that are concerned with inter- and intraprofessional relationship to come in conflict with the patient directed idealistic philosophy which has been one of the foundations of Western civilization.

It is of interest that the regulation of the activities of physicians, although usually accepted as a medical professional responsibility, has been, for a long time, the concern of lay authority.

The King of Babylon, Hammurabi, whose code of laws is the first we have, dating from some 2200 B.C., devoted 282 paragraphs to the regulation of the activities of physicians. The Babylonian Code set the fees that a physician could charge for his services and varied those fees according to the social status of the patient and his ability to pay. This society, over 4,200 years ago, also required that the physician make his services freely available to any citizen who needed them, regardless of his ability to pay. Hammurabi's code also set forth punishment for treatments that injured or killed, not punishment simply for the death of patients as is sometimes ascribed; but punishments for those *treatments* that either injured or killed. This same discipline is accepted by Hippocrates who in the essay entitled "Laws" set down the dictum; "In the first instance do no harm." This is a very ancient and yet timeless adjuration.

* * *

THE BASIC dilemma of the physician was recognized over 4,000 years ago as clearly as it was put by Shaw and Molière. In its simplest form, the dilemma asks, "Can the physician's dependence upon a livelihood that is largely based on illness coincide with a pure motivation for the health of the patient?"

One must answer this question with candor in terms of two ethics. The hedonistic ethic must say no. The idealistic ethic, which is the flower of Western civilization, must say yes.

It is this very fundamental dilemma that is at the heart of the ethics of the health professions. The Babylonian codes have become ancient history.

Neither Greece nor Rome at the time of their greatness had any laws that regulated the practice of Medicine. After the fall of Babylon, there were no laws regulating Medicine until the thirteenth century, in 1224 A.D., when Frederick II in Italy promulgated regulations which laid down the basic educational requirements for licensure to practice Medicine as well as the fees which could be collected. It was in educating physicians who could meet these standards that the famous school at Salerno grew. The requirements for licensure under Frederick II were, first, that before entering upon the study of Medicine the student should have studied for four years with the university faculty in Philosophy, in Mathematics, and in the Sciences. Thereupon, with the consent of the faculty, he may enter upon the four-year course of study in Medicine, at the completion of which time an examination is given by the state. Satisfying this, he may enter the practice of Medicine.

* * *

THE CONCERN OF society with the practice of Medicine is ancient indeed and the responsibility of the health worker to society goes back to the very earliest recorded times.

Between that period in the Greek tradition, when physicians had purely individual ethical responsibility and expressed it in their own regulation of professional practice, there was a long hiatus in professional responsibility until the late Renaissance period.

Then, with the growth of commercial guilds, there was also a parallel growth of Guilds of Physicians and Surgeons. It was an unhappy time for Medicine and for related health professions when they adopted specialty organizational patterns that originated in the market place. It is a *kind* of self regulation, but it is calculated to produce Hubris and to serve self-interest in the purest hedonist sense; rather than to be the kind of idealistic self-regulation that the Greek tradition handed down—the discipline of self-fulfillment in serving an ideal that is not now and never has been commonplace.

* * *

WAS HIPPOCRATES himself real? Is he some allegorical and mythical figure that has no substance? Historically, it is as early as the second century B.C. that we find commentaries on the Hippocratic writings; this being less than 200 years after his death. A larger number of commentaries exist from the first century. One of the most influential of later commentaries is that of Galen, who sometimes writes as if he had been a close personal friend of Hippocrates, but actually there was an interval of 600 years between their lives.

Hippocrates, from all the records that we have, was born on the island of Kos, which was early a satrapy of the Persian Empire and later fell to Sparta. As did many of the areas in the Greek Peloponnesus, Kos had a remarkable period of peace in about the fifth century and fourth century B.C. It was in this peaceful time that Hippocrates was born, about 460 B.C. He was taught Medicine by his father, in the tradition of that time. Heraclitus, the father of Hippocrates, was a physician of such note himself that his name has gone independently into medical history.

Hippocrates was a contemporary of Plato and in the dialogues called "Protagoras," "Phaedras," "Politica" one finds extended commentary on Hippocrates. There were two sons of Hippocrates, both of whom were physicians, one Phasicus and the other Draken, and they too had distinguished careers; the older forming a medical school which lasted for over 200 years. Hippocrates also had a son-in-law who was a physician. His grandfather, as well as his father, was a physician, and for a long time the writings of that Hippocrates of Nosedecus were confused with those of Hippocrates of Kos.

Hippocrates stood in the tradition of his time within four generations of physicians, each of which made contributions that bring their names down to this time. All we know about Hippocrates physically is that he was small. This is written by several of his contemporaries and they did not even justify it by saying he was handsome.

* * *

THE SOURCE OF the Hippocratic concept of Great Medicine is the same Greek tradition that has so deeply influenced our entire western civilization. It was Alcmaeon of Croton, one of the notable philosophers of the Pythagorean School, who first identified personal health as synonymous with an equilibrium in the body. The Pythagoreans were famed for the critical development of the concepts of balance and symmetry in games, art and philosophy. It was their treatment of numbers as the essence of balance and with figures that represented numbers that distinguish their philosophy.

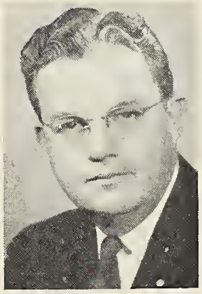
Out of this concept of truth, balance and beauty being in some way synonymous, the idea grew that health was not some supernatural gift. Rather, health was for the first time regarded as a balanced system of many parts. This fundamental concept is the very one that we accept today. It antedated the Hippocratic School, but was an important part of its conceptual heritage. The ideas of bodily equilibrium representing health and the restoration of equilibrium being the concern of the clinician are at the very foundation of Great Medicine as we know it today.

* * *

JUST AS TODAY all clinicians do not agree, there was in 400 B.C. a school on the island of Cnidus near Kos that focused its concern on the detailed diagnosis and immediate therapy of specific diseases. Cnidians sneered at the Hippocratic School on Kos because of its general philosophic attitude, its overweening interest in careful description, and its writings on general pathology rather than special pathology of specific disease. This argument has not been concluded in our time.

The Hippocratic Oath is not some archaic and private ritualistic incantation. It deals with human responsibility for the individual person and for humanity, so being timeless.

The earliest record of the Oath itself was not recorded until some 150 years after Hippocrates' death, by which time it is not at all clear that it represented his own writings. However, it did represent accurately the principles which I have described and its authorship is not essential to its meaning. These principles are as real and as sig-



THE AUTHOR
**Wm. N. Hubbard, M.D.**
Ann Arbor

nificant to us today as when they were first expressed in the time of the Golden Age of Greece.

The form of the Oath is inevitably characteristic of the time. There is first an invocation to the god Apollo who is the father of the man-god physician Aesculapius. Faith, All-Heal and Hygeia are called to witness. After this invocation, which is a religious one, there is the speaking of the indenture. This is again in the tradition of a time when the profession was passed from father to son; and the indenture is that the student will regard his teacher as father, will teach his sons the art and will not disclose the art to the uninitiated.

There follows the statement of the ethic which, quite simply, is the good of the patient. It is said elsewhere in the Hippocratic "Laws" that "the love of the art *is* the love of the patient" and so too *we* may add that the good of the patient is the foundation of the ethic.

Following next is a statement of professional decorum; that one will give no poisons, perform no abortion, make no debauchery or fornication on household members, and be no tale teller.

Finally, there is the Oath or commitment. The words in which this Oath was first expressed are Ionian Greek, a language which is no longer spoken. The gods that are called upon are no longer worshipped. Yet, the ancient principles of this Oath still find expression in modern words that are for us as meaningful as they were in ancient times.

A transliteration of the Oath in modern language is as follows:

*The invocation*—I do solemnly swear by that which I hold most sacred.

*The indenture*—that I will be loyal to the profession of Medicine and just and generous to its members.

*The statement of ethic*—that I will lead my life and practice my art in uprightness and honor; that unto whatsoever house I shall enter, it shall be for the good of the sick to the utmost of my power. I holding myself aloof from wrong, from corruption, from the tempting of others to vice, I will exercise my art solely for the good of my patient.

*And then a statement of decorum*—I will give no drug, perform no operation for a criminal purpose. That whatsoever I shall see or hear of the lives of men which is not fitting to be spoken, I will keep inviolably secret.

*And then, finally, the Oath or the commitment*—these things I do promise and in proportion as I am faithful to this my Oath, may happiness and good repute be ever mine—the opposite if I shall be forsworn.

* * *

I EMPHASIZE THAT these ancient words are not the only words that can express the thoughts behind them. It is this emphasis on the *idea* of the Oath that I would leave with you by sharing with you another expression of the ideals about which I spoke.

These are the words of a Rabbi—Moses Ben Maimon—who was the physician to Saladin the Golden; a great philosopher and teacher whose Anglicized name Maimonides is known to you. There is a prayer that bears his name.

> "I begin once more my daily work. Be Thou with me, almighty Father of mercy, in all my efforts to heal the sick. For without Thee, man is but a helpless creature. Grant that I may be filled with love for my art and for my fellow-men. May the thirst for gain and the desire for fame be far from my heart. For these are the enemies of pity and the ministers of hate. Grant that I may be able to devote myself, body and soul, to Thy children who suffer from pain.
>
> "Preserve my strength, that I may be able to restore the strength of the rich and the poor, the good and the bad, the friend and the foe. Let me see in the sufferer the man alone. When wiser men teach me, let me be humble to learn; for the mind of man is so puny, and the art of healing is so vast. But when fools are ready to advise me or to find fault with me, let me not listen to their folly. Let me be intent upon one thing, O Father of mercy, to be always merciful to Thy suffering children.
>
> "May there never rise in me the notion that I know enough, but give me the strength and leisure and zeal to enlarge my knowledge. Our work is great, and the mind of man presses forward forever. Thou hast chosen me in Thy grace, to watch over the life and death of Thy creatures. I am about to fulfill my duties. Guide me in this immense work so that it may be of avail."

---

## You Read It First

—The Labquick publication of the Ames Company in January, excerpted an article about "The Rapid Identification of Group A Streptococci in Throat Swabs, A Comparative Study of Two Methods" by Joseph A. Preston, M.D., Jackson, from the October issue of MICHIGAN MEDICINE.

—Geigy Pharmaceuticals will reprint from the June, 1963, issue of MICHIGAN MEDICINE the article about "Tandearil—Its Use in Plastic Surgery" by C. J. Hipps, M.D., and associates, Detroit.

—The Medical Tribune in its January 23 issue excerpted the guest editorial about "Concern for Crocks" by John V. Fopeano, M.D., Kalamazoo, which appeared in the December issue of MICHIGAN MEDICINE.

—The Current Medical Digest will reprint the complete guest editorial about "Concern for Crocks" by John V. Fopeano, from December MICHIGAN MEDICINE.

# Carcinoma in Situ of the Cervix with Genital Tract Extension

By R. R. MARGULIS, M.D.
R. W. DUSTIN, M.D.
G. D. DAUGHERTY, M.D.
Detroit

This paper is a follow-up of a previous report[15] dealing with an apparent paradox in semantics concerning a carcinoma limited to the epithelium of the cervix or cervical glands with the coincidental appearance of an identical lesion in the vagina, and, as in two of our cases, in the vulva also.

It has been realized with increasing frequency in the last five to seven years that carcinoma *in situ* of the cervix is not always a lesion localized to the cervix itself. More and more articles are appearing dealing with "multiple carcinoma *in situ*," "the second primary malignant tumor," "multicentric origins," and most recently, and perhaps most appropriately, McPherson and Biddle's use of the term, "regional epidermoid carcinoma."[18]

Since the first description of *in situ* lesions of the cervix by Rubin (1910), and Kermauner and Schottlaender (1912), a number of American authors—Schiller, Scipiades-Stevenson, Younge, McKelvey, Epperson-Hellman-Galvin—have contributed to the elucidation of various aspects of this pathological entity. Recently, Reagan's work in linking atypical cervical hyperplasia to carcinoma of the cervix *in situ* and invasive carcinoma, and the studies on microcarcinoma of the cervix have constructed a veritable rainbow of lesions, from reversible hyperplasia to the frankly malignant, irreversible invasive cancer.[25,26]

* * *

IN AN ATTEMPT to establish criteria for inclusion of cases in this report it is desirable to submit a definition of carcinoma *in situ*. Cellular disorganization of all epithelial layers with increased mitosis and atypical forms, without the normal maturation gradient from the basement membrane outward, may be said to represent an *in situ* lesion.[3,33] It is therefore obvious that superficial spread may be quite extensive without compromising this definition. Likewise, the discovery of this lesion in multiple areas of one organ, such as the cervix, is not improbable. The current report presents an extension of this thinking to include identical lesions found in adjacent organs of the genital tract. References can be found substantiating simultaneous carcinomas in varying combination in the vulva, vagina, cervix, tube, perineum, and urethra.[20,30,34]

## MATERIAL

Twelve cases are presented from private services of five Detroit area hospitals: Woman's Hospital, Receiving Hospital, and Henry Ford Hospital of Detroit; William Beaumont Hospital, Royal Oak; and St. Joseph Mercy Hospital, Pontiac. The patients' ages varied from 31 to 61 years, averaging 47.4 years. Four were nulliparous, the other eight having had from one to six children. Four cases are presented in some detail to demonstrate problems in diagnosis and management.

### Case #1 (J. H.—Receiving Hospital)

Fifty-four-year-old Negro female, gravida 1, para 0, was admitted to the Tumor Service on 7/2/59, having had a supracervical hysterectomy 29 years before, presenting complaint of spotting of three years' duration. There were no gross findings. A Papanicolaou smear in July, 1958, was reported as Class V. Biopsies and cold conization at that time showed only chronic cervicitis. Because of persistently positive Papanicolaou smears, sections were recut, and the diagnosis of carcinoma *in situ* of the cervix was made. Most of the cervix was removed with cold conization, and she was followed with Papanicolaou smears which in August, 1958, remained persistently positive. At this time an abdominal cervicectomy was done with a diagnosis of foreign body granuloma.

In October, 1959, because of persistently positive smears, vaginal biopsies were carried out with a diagnosis of vaginitis. Smears continued to be positive. Partial vaginectomy was accomplished in February, 1961, with a diagnosis of carcinoma *in situ* of the vagina. Follow-up Papanicolaou smears since that date have been negative.

### Case #2 (A. K.—Receiving Hospital)

Thirty-six-year-old Negro, gravida 6, para 6, was admitted in April, 1959, with spotting and post-coital bleeding of one year's duration. Gross findings included a cervical erosion which bled to the touch and which when biopsied showed carcinoma *in situ* of the cervix. Conization was then done with the diagnosis of carcinoma *in situ* con-

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This paper was presented at the Central Association of Obstetricians and Gynecologists Meeting in Denver, Colorado, September, 1963.

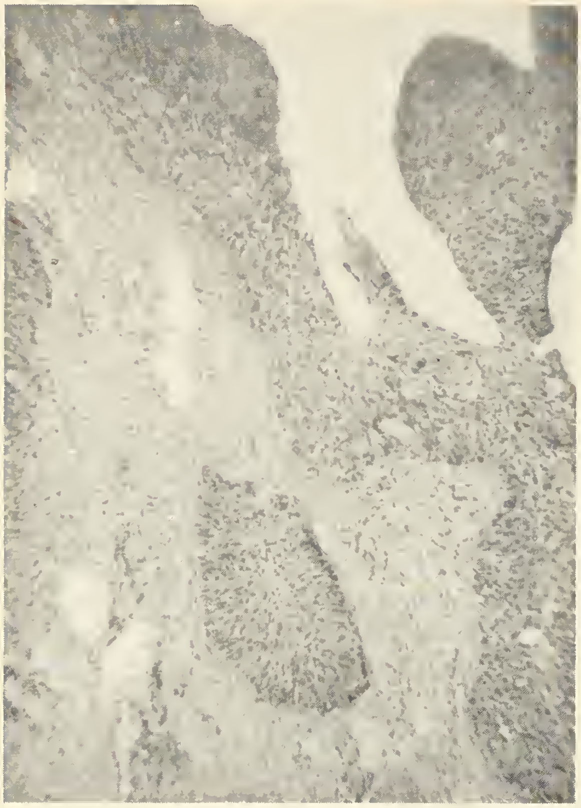

Fig. 1. Case No. 4. Low power section of cervix showing carcinoma *in situ*.

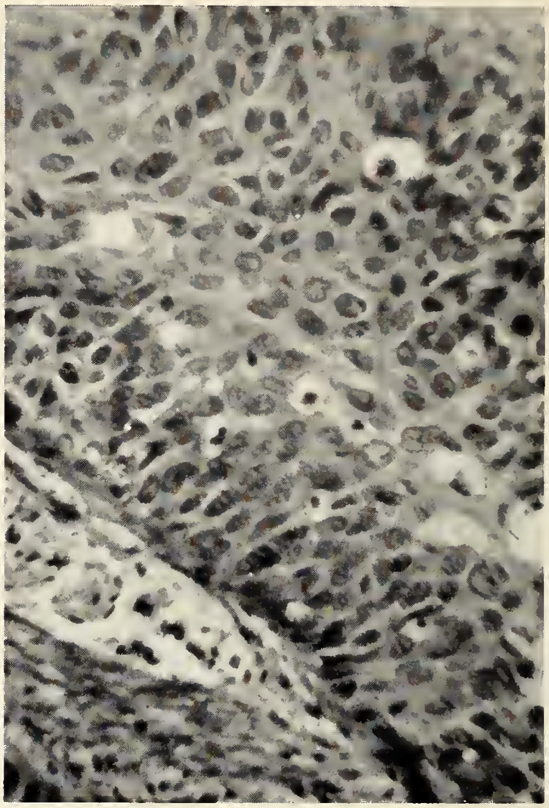

Fig. 2. Case No. 4. High power field of cervix showing mitotic activity and atypia.

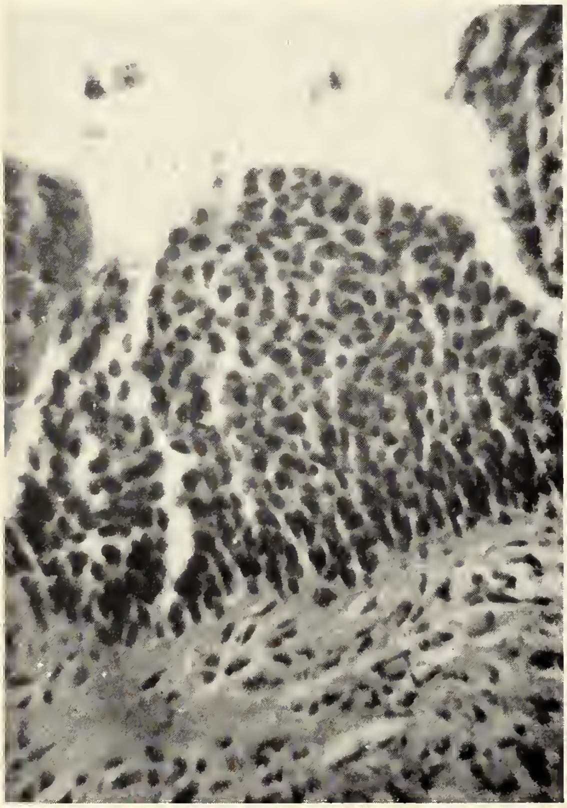

Fig. 4. Case No. 4. High power field of vaginal biopsy. Note disorganization and anaplasia through entire epithelium.

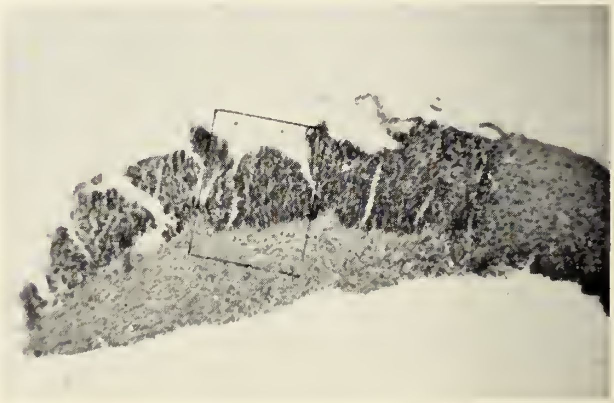

Fig. 3. Case No. 4. Low power view of vaginal biopsy. (Outlined section enlarged in Figure 4.)

firmed. Total hysterectomy was done in May, 1959, with the diagnosis of persistent carcinoma *in situ* of the cervix only.

Papanicolaou smears remained persistently positive, and a vaginal biopsy in February of 1960 showed carcinoma *in situ* of the vagina. A partial vaginectomy was carried out in March, 1960, with the diagnosis of carcinoma *in situ* of the vagina. Papanicolaou smears since then have been persistently negative.

**Case #3 (E. J.—William Beaumont Hospital)**

Fifty-four-year-old white, gravida 3, para 3, first seen in 1955 with a history of two months of spotting. Gross findings included cystocele, rectocele, and cervical erosion. A D & C and cold conization of the cervix were carried out which revealed carcinoma *in situ* of the cervix. This was followed by an abdominal hysterectomy, bilateral salpingo-oophorectomy, with removal of the large segment of vaginal cuff. Pathology report showed residual carcinoma *in situ* of the cervix and in the cuff. Papanicolaou smears following this procedure were negative two years. The patient then developed pruritis vulvae which was grossly felt to be leukoplakia. Vulvar biopsy was carried out which revealed a carcinoma *in situ* of the vulva.

An anterior-posterior repair and a simple vulvectomy were carried out in conjunction with biopsies of the apex of the vagina. The pathologist felt that the vulva represented Bowen's Disease. The vaginal biopsies were negative. The patient presented herself for follow-up examination, and a Class III Papanicolaou smear was found. Schiller staining of the vaginal apex revealed a suspicious area. Excisional biopsies of the vaginal apex were again carried out with a healthy margin of stained tissue removed. Carcinoma *in situ* was diagnosed on these biopsies. Papanicolaou smears and Schiller staining for the past year have been negative.

#### Case #4 (R. S.—William Beaumont Hospital)

A 47-year-old nulligravida was first seen in May, 1958, at which time a diagnosis of carcinoma *in situ* of the cervix was made by cervical biopsy. In the same month a tubovarian abscess was discovered and removed by salpingo-oophorectomy. Cervical smears in the summer of 1958 were still found to be Class V. In October of 1958 a total hysterectomy was done which showed residual *in situ* carcinoma of the cervix. In January, 1960, the Papanicolaou smears were Class II, but in February, 1961, they were found to be Class IV. A nonstained area in the vaginal apex was discovered with Schiller staining, and this was biopsied. This was diagnosed as carcinoma *in situ* of the vaginal mucosa.

Subsequent smears in May of 1961 and in February of 1962 were Class III. No malignant cells have been discovered, and the vaginal mucosa continues to stain with Schiller stain normally. The patient is, at present being observed closely (see Figs. 1-4).

### GROSS CHARACTERISTICS

It is not surprising to note the complete absence of any distinguishing gross characteristics in the cervices of these women. Some were grossly normal; others showed varying degrees of cervicitis and/or erosion. We are, however, disappointed in the infrequency with which the Schiller test was used in this series.[21] Despite the proven value of this procedure, on only three occasions was the Schiller method used. Ten of the twelve patients, six asymptomatic, had initial Papanicolaou smears ranging from Class III through Class V, thereby warning the clinician that further diagnostic studies were required. The remaining two had symptoms warranting diagnostic procedures beyond mere screening. In one of these the lesion was discovered as a superficial ulceration in the vagina.

Three patients had had a previous supracervical hysterectomy, two, eight, and 29 years prior to the establishment of the diagnosis of carcinoma *in situ* of the cervix. While in the first case one could speculate that the lesion existed at the time of the original surgery, in the latter two this would be a very unlikely conjecture, and we would consider these as new lesions. The value of careful follow-up is exemplified by cases 1, 2, 3, and 4, in which a persistent or recurrent lesion was found. (See Table I.)

TABLE I. INITIAL SYMPTOMS AND GROSS FINDINGS

| | |
|---|---|
| No symptoms | 6 |
| Bleeding or spotting | 6 |
| No findings present | 8 |
| Cervical ulceration or erosion | 3 |
| Vaginal ulceration | 1 |

TABLE II. METHODS OF ESTABLISHING DIAGNOSIS

| | |
|---|---|
| Papanicolaou smear | 10 |
| Cold conization | 7 |
| Biopsy of cervix | 5 |
| Biopsy of vagina | 5 |
| Schiller staining | 3 |

### MICROSCOPIC FINDINGS

The microscopic slides were read by the hospital pathologist of one of the five hospitals participating in this study. But for three cases where the slides were not available, they were also reviewed by at least two of the authors. Except for three cases, the description coincided with the classical microscopic picture of carcinoma *in situ*. In these three the lesion may have extended in one or two spots for a few cells beyond the, possibly artificial, baseline membrane.

The pathologists reviewing these three cases were in disagreement regarding the classifying of these lesions. The majority opinion favored the diagnosis of carcinoma *in situ*, but there was also the opinion voiced of a microcarcinoma, sometimes called carcinoma with early superficial invasion. Two patients presented *in situ* lesions of the cervix, vaginal vault, and vulva. The latter was labeled either as Bowen's Disease or carcinoma *in situ* of the vulva. The lesions in the vagina showed the same histopathological characteristics as the lesions in the cervix. The vaginal, cervical, and vulvar lesions were multicentric. A recurrence of positive Papanicolaou smears following removal of the vaginal lesion was encountered five times. This was managed by partial vaginectomy (2 cases), excisional biopsy (2 cases), and in one case the patient refused treatment. (Cases 1, 2, 4, 9, and 12.)

In the treated four cases, histology confirmed the cytological diagnosis of cancer *in situ*. After vaginal surgery for a recurrent lesion, follow-up extending from two to four years did not reveal any positive Papanicolaou smears. The one patient who did not receive any further surgery, despite the positive Papanicolaou smear found on follow-up examination, was tested with Schiller solution for localization of tissue changes to delineate an area for biopsy. No gross lesion or lack of iodine uptake was noted, and therefore a continuing watchful follow-up is practiced. (See Table II.)

**TABLE III. OCCURENCE OF GENITAL EXTENSION OF CA IN SITU FOLLOWING INITIAL TREATMENT**

| Case | Interval* | Organ Involvement |
|---|---|---|
| A. K. | 10 months | Vagina |
| E. J. | 24 months | Vulva |
|  | 6 years | Vagina |
| R. S. | 28 months | Vagina |
| L W. | 6 months | Vagina |
| F B. | 12 months | Vulva |
| J. S. | 20 months | Vagina |
| L. S. | 6 months | Vagina |
| B. M. | 6 months | Vagina |

*Interval between abdominal hysterectomy and diagnosis of recurrence or extension.

**TABLE V. FOLLOW-UP AFTER INITIAL TREATMENT**

| | |
|---|---|
| *Pap Smears:* | |
| Class I & II | 3 |
| Class III | 2 |
| Class IV & V | 7 |
| *Management of:* | |
| Class III: | |
| Excision biopsy | 2 |
| Class IV & V: | |
| Excision biopsy | 2 |
| Partial vaginectomy | 5 |

## MANAGEMENT

(See Table III.)

Since these twelve cases originate from different gynecologists and different hospitals, treatment, and even the diagnostic procedures used in the discussed cases, varied. From Table IV it is apparent that the diagnosis was established either by routine smear or biopsy of the cervix, or vagina, whenever suspicion arose (spotting, bleeding, erosion, ulceration). Whenever a positive Papanicolaou smear was obtained, except for four patients, cold cervical cone was done for definitive diagnosis.

Total abdominal hysterectomy, with or without vaginal cuff excision, simple excision of the vaginal lesion, and radium needle insertion into the vaginal lesion after previous hysterectomy were all used in the management of these patients. In the three patients having had supracervical hysterectomy, excision of the cervical stump (two vaginally, one abdominally) was performed. In five cases partial vaginectomy for recurrent vaginal lesions was carried out, while simple vulvectomy was done on two occasions. From Table IV the age, parity, preliminary and definitive diagnostic procedures, management of the cervical lesion, and follow-up are visualized. The importance of follow-up is evidenced by the seven cases in which the follow-up Papanicolaou smears revealed the necessity for further surgery. This was done in six instances. (See Table V.)

## DISCUSSION

Discussion of this topic divides itself logically into sections dealing with (1) diagnostic procedures, (2) management, (3) follow-up, (4) management of positive findings on follow-up, and (5) etiology. Carcinoma *in situ* of the cervix is classically a lesion described within certain rather rigid criteria, and yet if twenty slides are presented to several competent pathologists, there will be disagreement in many instances as to the exact nature of the pathology present. Diagnoses will vary from severe dysplasia to very early superficial invasion (recently called microcarcinoma). The gynecologist is thus faced with a dilemma as to what constitutes good definitive management. In some instances, age and future childbearing make conservative management advisable. The clinician is increasingly oriented to the use of hysterectomy as treatment for carcinoma *in situ.*

The evidence of involvement of adjacent structures with carcinoma *in situ* of the cervix imposes a need for more detailed diagnostic procedures with any cervical lesion. It is considered routine that every female patient should have at least annual Papanicolaou smears, despite the small return of 0.8 to 1 per cent positive smears.

In view of the possibility of carcinoma *in situ* of the cervix with extension to the vagina, or a multiple carcinoma, we feel that a differential Papanicolaou smear is of value, and the additional slides may prove rewarding in obtaining further information. We are suggesting the following for differential Papanicolaou smears:

1. Aspiration of the endocervix
2. Scraping of the squamocolumnar junction with an Ayre's spatula
3. Scraping of the upper fourth of the vagina
4. Only in the presence of other genito-urinary malignancy is vulvar scraping obtained.

Since several laboratories were reporting on these smears, it is important that the gynecologist knows the meaning of the pathologist's classification of Papanicolaou smears. While there is little doubt as to Class V, more variation in interpretation exists in Class III, less in Class IV. While the Class III smears were either repeated or the cervices biopsied, uniformly Class IV and Class V patients were hospitalized, where a cervical cold cone was the preferred diagnostic procedure, in contradistinction to the minority of cases in which the "Boston management" of multiple punch biopsies of the cervix was followed.

At this point one has to admire the European gynecologists in their quest for the early detection of cancer by the use of the colposcope and colpomicroscope. While these methods are very seldom used in this hemisphere, the routine screening of the female population with smears has produced excellent results.

The Schiller Test, an old aid to the gynecologist, is rightfully regaining its place in the management of carcinoma *in situ*, with special reference to carci-

TABLE IV. DATA FOR 12 PATIENTS WITH CARCINOMA IN SITU WITH EXTENSION INTO UPPER VAGINA

| Patient | Age | Parity | Symptoms | Objective Evidence | Papanicolaou Smears | Pathology | Treatment | Follow-Up |
|---|---|---|---|---|---|---|---|---|
| J. H.<br>(R. H.)<br>No. 1 | 54 | 0 | Spotting 3 years | None | Class V | Chr. cervicitis (on recut, ca. *in situ*). | (Supracervical hyst. 29 years prior.) Biopsy of Cx. Cold cone of Cx. | Pap. V |
| | | | | | | | Abdominal cervicectomy. | Pap. V |
| | | | | | | Vaginitis | Vag. biopsies | Pap. V |
| | | | | | | Ca. *in situ* of vagina | Partial vaginectomy | LW 2½ yrs. FU Pap. neg. |
| A. K.<br>(R. H.)<br>No. 2 | 36 | 6 | Spotting, post-coital bleeding | Lesion bled to touch | None | Ca. *in situ* of cervix. | Biopsy of cx. Cold cone of cervix. | |
| | | | | | | Ca. *in situ* of cervix. | Total abd. hyst. | Pap. V |
| | | | | | | Ca. *in situ* of vagina. | Vag. biopsy | Pap. V |
| | | | | | | | Partial vaginectomy. | LW 3 yrs. FU Pap. neg. |
| E. J.<br>(W. B. H.)<br>No. 3 | 52 | 3 | Spotting | Cervical erosion | None | Ca. *in situ* of cervix and extension in vag. cuff. | Cold cone. Abd. hyst., bil. S-O; large vag. cuff. | LW 2 years |
| | | | Pruritis | | | Ca. vulva *in situ*. Focal ca. apex of vagina *in situ*. | Simple vulvectomy. Schiller stain. Exc. biopsy of vag. | Pap. III Leukoplakia, ca. of vulva *in situ* (Bowen's) FU Pap. neg. LW 1 more year. |
| R. S.<br>(W. B. H.)<br>No. 4 | 47 | 0 | None | None | Class V | Ca. *in situ* of cervix. | Biopsy of cx. S-O. | |
| | | | | | | Ca. *in situ* of vagina. | Total hyst. Exc. vag. biopsy. Schiller stain. | Pap. IV<br>LW 2½ yrs. Pap. III |
| L. W.<br>(S. J. H.)<br>No. 5 | 44 | 0 | None | None | Class V | Ca. *in situ* of cervix. | Cold cone; abd. hyst. with cuff. | |
| | | | | | | 6 mo. later, ca. *in situ* of vag. | Radium needles in vagina. | LW 3 yrs. FU Pap. neg. |
| F. B.<br>(W. H.)<br>No. 6 | 31 | 0 | None | None | Class V | Ca. *in situ* of cervix and extension in vag. cuff | Cold cone; abd. hyst. with large vaginal cuff. | Bowen's dis. of vulva 1 yr. later; vulvec. LW 5 years. FU Pap. neg. |
| M. K.<br>(W. H.)<br>No. 7 | 54 | 1 | Spotting | Vagina grossly susp. ca. | Class V | Ca. *in situ* of cervix and vag. | Cold cone. Radium to cx. and vagina. | LW 3½ yrs. FU Pap. neg. |
| J. S.<br>(H. F. H.)<br>No. 8 | 41 | 2 | None | None | Class V | Ca. *in situ* of cervix with extensive-gland involvement. | Biopsy of cx., abd. hyst., bil. S-O. | LW 2 yrs. Pap. V |
| | | | | | | 20 mo. later, ca. *in situ* of vag. | Exc. upper vag. and radium insert. | Lost to FU |
| J. P.<br>(W. H.)<br>No. 9 | 54 | 3 | Spotting 2 years after subtotal hyst. | Cx. and vag. grossly susp. (ulcer) | Class III | Ca. *in situ* of cervix with same lesion in vagina. | Biopsy of cx., exc. of cervical stump. | LW 2 yrs. Class III Pap. 4 yrs. ago. Biopsy of vag. neg. Lost to FU. |
| L. S.<br>(H. F. H.)<br>No. 10 | 61 | 2 | None | None | Class V | Ca. *in situ* of cervix. | Cold cone, abd. hyst. | Pap. V |
| | | | | | | 6 mo. later ca. *in situ* of vag. | Exc. upper vag. (Schiller pos.) | LW 4 yrs. FU Pap. neg. |
| B. M.<br>(H. F. H.)<br>No. 11 | 56 | 1 | Bleeding | None | Class IV | Ca. *in situ* of cervix | D & C, abd. hyst. cold cone. | Pap. V |
| | | | | | | 6 mo. later, ca. *in situ* of vag. | Exc. upper vag. | LW 2½ yrs. FU Pap. neg. |
| O. M.<br>(R. H.)<br>No. 12 | 35 | 3 | None | None | Class V | Ca. *in situ* of cx. and vag. | Supracerv. hyst. 8 yrs. prior. Punch biopsy of cervix; vaginal cervicectomy and vag. biopsy. | LW 1 yr. Pap V. Pt. refused further Rx. |

noma *in situ* of the cervix with possible extension to the vaginal vault. It is necessary to stress the fact that a positive Schiller test—non-stained part of the cervix—*per se*, does not connote malignancy. The lack of iodine uptake is seen in several benign conditions and implies only a deficiency of cellular glycogen content. Failure of Schiller staining will guide the gynecologist to the site of the cone, and in definitive treatment will delineate how much vaginal cuff should be removed.

When symptomatology warrants, the patient is hospitalized, and the cervix, upper vagina, and vulva are stained with Schiller's or Lugol's solution. In addition to the cervical cone, spot biopsies of vagina and/or vulva must be taken if indicated by lack of iodine uptake. A cervical cone should be performed on indication whether pregnancy exists or not. Prior to cone, no electric cauterization should be used, so that the tissue is not distorted when viewed by the pathologist. It is important that the cone be taken with a margin of normally stained tissue in order not to be misled by biopsying the edge of an invasive carcinoma with the probability of an *in-situ* pathology report. Once a diagnosis of carcinoma *in situ* is obtained, it is our practice to review the slides ourselves and to assess the severity of the dysplasia or anaplasia present and the extent of the lesion, both as to periphery and depth.

In view of some studies, recording up to 50 per cent persistence of the *in-situ* lesions in hysterectomy specimens, and except where considerations of age and childbearing are of paramount importance, removal of the cancer-bearing organs is mandatory. Many modifications as to definitive treatment are listed in the literature, varying from cold cone to extended hysterectomy.

The ideal approach to the management of carcinoma *in situ* would be vaginal hysterectomy, since it offers the operator an opportunity to get as much vaginal cuff as defined from previously applied Schiller stain. Despite this academic approach to management, not a single case was handled by this method in the presented series. All cases, unless a previous supracervical hysterectomy had been performed, were treated by abdominal hysterectomy in which less than one-half of the cases had adequate vaginal cuff removal at the time of original surgery, as judged by the operative note or by subsequent persistence of positive Papanicolaou smears and further assessment of vaginal lesions. Whenever a diagnosis of carcinoma *in situ* of the cervical stump is obtained, vaginal excision of the stump with adjacent cuff would appear to be a more adequate and a simpler management than abdominal cervicectomy. The follow-up is of equal importance in the management of carcinoma *in situ* of the cervix, especially in cases where extension to the vaginal cuff is found at the time of surgery.

We are proposing both Papanicolaou smears, scraping of the vaginal apex and adjacent vagina, and subsequent staining of the vagina with Schiller solution at 3-month, 6-month, and 12-month intervals post-operatively and semi-annually thereafter. Whenever either a Papanicolaou smear of Class III or higher or a positive Schiller area is obtained, further investigation with an excision biopsy is mandatory.

At this stage we are depending on the pathology to indicate whether (1) this is a histologically identical lesion compared to the previous neoplasm, (2) whether a border of healthy tissue surrounds the excisional biopsy, and (3) whether there are invasive changes present. If we are satisfied that we are dealing with an *in-situ* lesion with a sufficient margin of healthy tissue surrounding the biopsy, no further surgery is contemplated and the patient is followed as outlined above.

Wherever a doubt exists that the biopsy cuts through neoplasm, a partial vaginectomy is undertaken. In cases not encountered in this series, where invasive changes do exist, management will be undertaken as for metastasis of invasive carcinoma or for a primary invasive carcinoma of the vagina. The choice should be either radiation therapy or, if the gynecologist is capable, the performance of radical surgery. In one of our cases, the extension of carcinoma *in situ* to the vagina was treated with insertion of radium needles. In another, both cervix and vagina were treated with routine irradiation therapy (Ernst applicator). While this is considered overtreating carcinoma *in situ* with vault extension, this was justifiable, since the possibility of early invasion was considered by one of the reviewing pathologists.

Recently the term, microcarcinoma, or carcinoma with early superficial invasion,[23,24] is more often seen in the literature, and the management with complete extrafascial hysterectomy without oophorectomy has proven to be sufficient as compared to radiation therapy which would castrate the patient.

We do not feel the removal of the tubes and ovaries would contribute to an increased cure rate.

When one finds a seeming paradox such as described herein, it is always tempting to theorize as to why an *in situ* lesion should involve adjacent or even somewhat distant normal tissue. Several hypotheses have been advanced, though none seems to explain all instances. We ourselves have previously subscribed to the belief that these tissues, presumably of similar embryologic origin, may respond to a common cancerogenic stress with a definite, typical histologic pattern. This hypothesis has been shaken by newer evidence suggesting that the upper one-fourth of the vagina may not be of mullerian origin,[34] and, at any rate, common embryology cannot be used to explain simultaneous vulvar and cervical involvement by *in situ* lesions.

The work of Woodruff and Williams[34] with immature female fetuses led them to the conclusion that the lower genital tract does not stem from common embryologic origin. Certainly the relative susceptibility of the ectocervix, vagina, and vulva to carcinoma is not similar, nor are the histologic patterns of the mature cancers of these organs.

Despite these findings, the possibility of a regional response of undifferentiated genital tract cells to a carcinogenic agent must be considered, with a resultant multicentric shower of carcinomata *in situ*.[18,19]

Are these simultaneous or recurrent vaginal and vulvar lesions simply new primary growths without any relationship to the cervical lesion originally diagnosed? If we adhere closely to Bilroth's criteria for such lesions, the answer must be "No," since the extensions are histologically identical to the originals, yet there can be little doubt that one malignancy in the genital tract predisposes to the findings of others in the same region in any given patient. "Cancerization" or a form of "creeping spread" is a term which has been used to describe the growth pattern of these lesions by Willis, Brunschwig, et al. Presumably, this ability to spread superficially is dependent upon inherent changes in the epithelial cells which will become involved by *in-situ* carcinoma.

There is no doubt that in some of the cases we have recorded, inadequate initial therapy or original diagnostic failure is responsible for the persistence of positive Papanicolaou smears or the relatively prompt discovery of vaginal lesions following hysterectomy for unrelated reasons. Schiller staining, routine Papanicolaou smears, and total hysterectomy with adequate cuff excision should eliminate most cases in this category.

It is unlikely that irradiation as a carcinogenic agent played any role in the production of lesions in this series, since in only one case (Table IV) was irradiation used as the primary treatment for the *in situ* carcinoma, and in this instance a grossly suspicious microscopically proven vaginal *in situ* lesion was already present. We must therefore conclude that multiple carcinomata *in situ* in the genital region frequently arise multicentrically for reasons which are still not known with certainty.

## SUMMARY

Presented are twelve patients with carcinoma *in situ* of the cervix with vaginal vault extension. This apparent paradox is illustrated with slides from tissue of the cervix and vagina showing histopathologic characteristics of non-invasive lesions limited to the epithelium of the vagina and cervix, not traversing the basal membrane or extending beyond the cervical glands. Two patients showed in addition to the involvement of the cervix and vaginal vault the same *in-situ* lesion of the vulva. The vaginal vault extension was discovered either at the time of the original surgery or during the frequent follow-up examinations.

In order to discover the extension of the *in situ* lesions, certain steps in diagnosis and management are stressed: (1) Differential Papanicolaou smears (cervix, endocervical canal, vaginal vault, and vulva when indicated). (2) Preoperative staining of cervix and vagina with Schiller's solution. Definitive diagnosis with a surgical cold cone. (3) Definitive management: Vaginal or abdominal hysterectomy with excision of the upper one-fourth of the vagina. (4) Careful follow-up. The etiology of this paradoxical involvement of the cervix and vaginal vault is discussed.

We would like to thank Drs. T. Ling, H. Longyear, J. P. Pratt, L. B. Stevenson, and C. Wright for permitting us to incorporate their cases in this survey.

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(Continued on Page 272)

# Amniotic Fluid Spectral Absorption In the Management of Rh Sensitization

By **FRANK J. SCHRADER, M.D., BYRNE R. MARSHALL, M.D., BRUCE A. WORK, M.D., and TOMMY N. EVANS, M.D.**
**Ann Arbor**

Early fetal death from erythroblastosis with a homozygous father establishes a poor prognosis for future pregnancies. There may never be subsequent fetal survival unless some means is found to neutralize Rh antibodies. Decreased perinatal mortality from erythroblastosis has resulted from pre-term delivery,[2] exchange transfusion, and a reduction in incompatible blood transfusions. The frequency of isoimmunization may be less when manual removal of the placenta and operative delivery can be avoided.[8]

Prediction of the severity of fetal hemolytic disease has been based on maternal antibody titers and the obstetric history. However, low levels of Rh antibodies may be associated with severe erythroblastosis.[10] All subsequent siblings of an erythroblastotic infant with a homozygous Rh positive father will probably be affected. The prenatal diagnosis of erythroblastosis has been less certain when the father is heterozygous. Increases in Rh antibody titers have been reported with an Rh negative fetus after a previous sensitizing pregnancy.[10]

Bevis[1] first recognized a characteristic spectral absorption pattern of amniotic fluid with an erythroblastotic fetus (Fig. 1). Compared with the curve of a normal infant (Fig. 2), there is a definite rise at the 450 millimicron wave length. Liley[5,6] found that the optical density at 450 millimicrons is inversely proportional to the umbilical cord hemoglobin. A probability chart was constructed from these observations.[6]

* * *

THIS REPORT deals with our experience in determining spectral absorption curves on amniotic fluid from 20 Rh sensitized women.

## Materials and Methods:

Amniotic fluid (15 to 20 cc) was collected by abdominal amniocentesis.[4] Most samples were obtained between 30 and 35 weeks gestation. Isotopic placental localization and abdominal palpa-

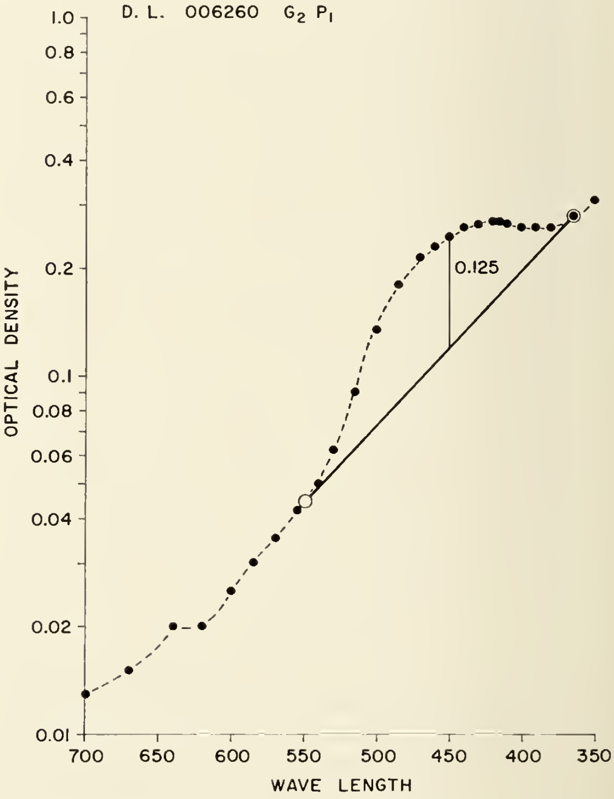

Fig. 1. A peak at 450 millimicrons characterizes the spectral absorption curve of amniotic fluid with an erythroblastotic fetus.

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From the Department of Obstetrics and Gynecology, University of Michigan.

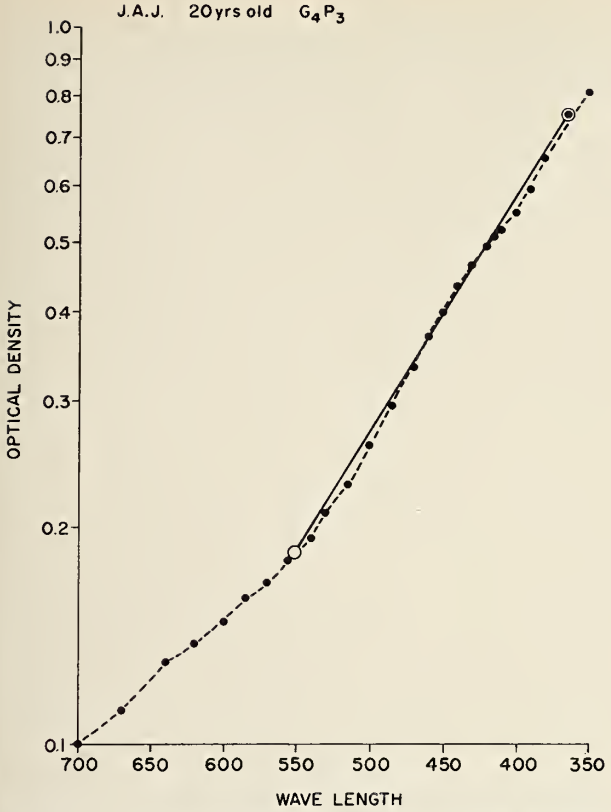

Fig. 2. Spectral absorption pattern of normal amniotic fluid.

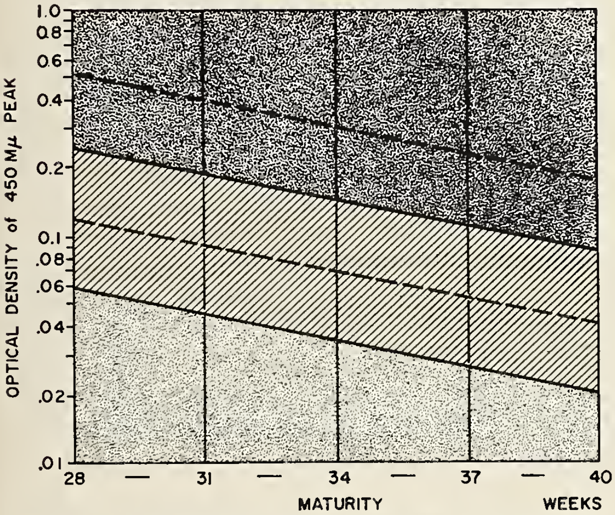

Fig. 3. A modification of the Liley prediction chart indicating upper, mid and lower zones.

tion of the fetal position aided in selection of the puncture site. The bladder should be empty. Under aseptic conditions and local anesthesia, an 18-gauge spinal needle with the stylet in place was inserted midway between the umbilicus and symphysis pubis 2 centimeters from the mid-line on the side of the fetal small parts.

After centrifuging the amniotic fluid at 2500 rpm for 5 minutes, the supernate is filtered through #42 Whatman filter paper. The sterile fluid may be stored in a refrigerator for several months or at room temperature for 30 days without analytic alteration if it is protected from light. Fifteen minutes exposure to sunlight or 10 hours to indirect light may invalidate the spectral absorption curve.[5] These properties have enabled us to establish a postal service for amniotic fluid analysis for physicians in our area.

Each specimen was analyzed in a Coleman Spectrophotometer with determinations at 26 wave lengths between 350 and 700 millimicrons. The values were plotted on a logarithm scale against the wave lengths. A baseline was obtained by drawing a straight line between the points at 550 and 365 millimicrons. The height of the pigment peak at 450 millimicrons was measured and plotted on the probability chart.

A modification of the Liley prediction chart is presented in Figure 3. The upper zone indicates severe, the mid-zone moderate, and the bottom zone mild erythroblastosis or an unaffected fetus. Infants were classified as mildly affected or unaffected if a single optical density was in the lower zone of the prediction chart or two or more consecutive values showed a falling optical density. Severe disease is suggested by a single value in the upper zone or increasing mid-zone values. Multiple analyses were used when possible.

## *Results:*

Prediction of severity of hemolytic disease in 20 Rh sensitized infants is presented in Table I. All infants predicted to be normal or mildly affected did well. Five of these were Rh negative. All four Rh positive infants had positive Coombs tests. Infants predicted to be moderately affected did well after exchange transfusion. All predictions of moderate disease were based upon one analysis. All of

TABLE I. PREDICTION OF THE SEVERITY OF RH HEMOLYTIC DISEASE UTILIZING THE SPECTRAL ABSORPTION PATTERN OF AMNIOTIC FLUID

| Prediction | No. Patients | Stillbirths | Neonatal Deaths | Avg. No. Exchanges | Avg. Cord Hgb. | Survival |
|---|---|---|---|---|---|---|
| Mild or Unaffected | 9 | 0 | 0 | 0 | 16.5 | 100% |
| Moderately Affected | 4 | 0 | 0 | 2.5 | 13.1 | 100% |
| Severely Affected | 7 | 3 | 4 | 1.25 | 11.1 | 0% |

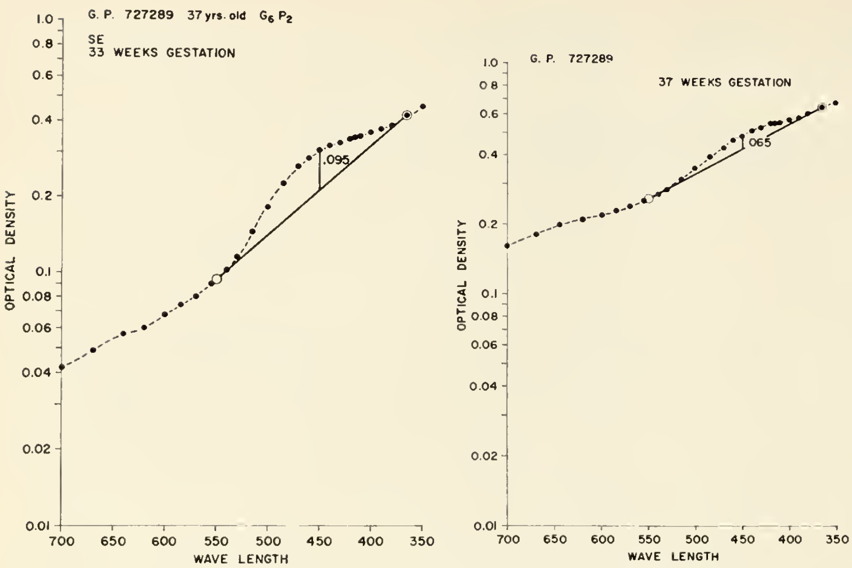

Fig. 4. Falling optical densities suggest a mildly affected or normal fetus.

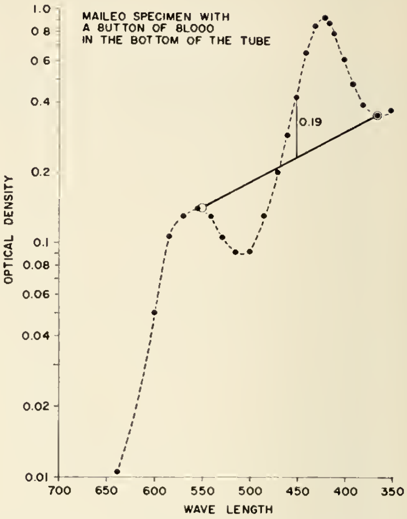

Fig. 5. Alternation of the spectral absorption pattern by contamination of amniotic fluid with blood.

these fell into the upper mid-zone of the prediction chart.

Seven infants were predicted to be severely affected. Three intrauterine deaths occurred at 32, 35, and 37 weeks of pregnancy. Four were delivered at 34 to 36 weeks. Two died during exchange transfusion and two after 48 hours.

Early in our experience an arithmetical error was made in calculating optical density in a patient with a heterozygous husband. Interpretation of the absorption curve suggested severe erythroblastosis and premature delivery was advised. The infant was Rh negative and survived despite early delivery.

Amniotic fluid from a normal or mildly affected fetus may show an increased optical density between 30 and 35 weeks of pregnancy. This peak will diminish as term approaches (Fig. 4). This is most likely to occur with mid-zone curves and emphasizes the value of multiple analyses.

## *Discussion:*

No complications have resulted from the amniocenteses reported here. Amnionitis following amniocentesis has occurred.[4] Zipursky[9] suggested that transplacental hemorrhage from amniocentesis may cause sensitization and increase the severity of hemolytic disease. Fairweather[3] analyzed 145 cases and found no evidence that amniocentesis increased the severity of erythroblastosis. Localization of the placenta with radiography or radioactive isotopes reduces the chance of placental damage.

Sources of error in evaluation of pigment peaks have been described.[6] In our experience, the most frequent difficulty has resulted from miscalculation of gestational age and contamination of the fluid with blood (Fig. 5). The latter can be minimized by prompt centrifugation of the fluid.

Spectrophotometric amniotic fluid analysis is of greatest value in establishing the prenatal diagnosis of erythroblastosis when the father is heterozygous Rh positive. Prediction of the severity of erythroblastosis aids in timing delivery. Although uncommon, perinatal death of a first affected infant may occur.[7] Prenatal diagnosis, prompt timing of delivery and immediate neonatal treatment offer the best prognosis. Subsequent infants may be more severely affected.

Preterm or even premature delivery may provide the only chance for survival when the optical density falls in the upper zone of the prediction chart. Prematurity is usually not a survival factor with delivery after the 36th week. Earlier delivery has yielded little increase in fetal salvage and should be resorted to only when the spectral absorption curve reflects severe disease or when there has been previous premature fetal death with a homozygous Rh positive father.

A suggested regimen for the detection and management of Rh hemolytic diseases is as follows:

1. Papain screening of all patients at the time of the first prenatal visit to detect sensitization.
2. Repetition of antibody studies at 30 weeks of pregnancy.
3. Spectrophotometric analysis of amniotic fluid from all sensitized patients at 30 to 34 weeks of pregnancy.
4. If the spectral absorption curve suggests mild

*(Continued on Page 272)*

# A CASE REPORT:

## *Familial Occurrence of Idiopathic Thrombocytopenic Purpura and Systemic Lupus Erythematosus*

**By JOSEPH M. KOPMEYER, M.D.**

Two cases are reported: Case 1 is a 35-year-old negro female diagnosed as idiopathic thrombocytopenic purpura (ITP) in 1954, and Case 2 is the mother of Case 1, a 57-year-old female who was found to have systemic lupus erythematosus (SLE) in 1959.

The occurrence of "idiopathic" thrombocytopenic purpura as a prodromal symptom of SLE is discussed. Studies of relatives of SLE patients relating to abnormalities in serum proteins would seem to favor some dysfunction in production of gamma globulins as a factor in the pathogenesis of collagen disorders.

The LE cell phenomenon is briefly discussed and compared to newer tests for other antinuclear factors in serum.

The occurrence of identical high titers of antinuclear factors in the sera of both patients would seem to favor the possibility of SLE in the daughter as well as the mother. Thus far, however, routine LE cell preparations are negative when the daughter is tested.

The familial occurrence of systemic lupus erythematosus (SLE) has been the subject of several reports, 44 cases in 20 families being recorded up to 1961.[1] The relationship of "idiopathic" thrombocytopenic purpura (ITP) to SLE[2,3] has also occasioned considerable interest in recent years. The view has been expressed by Dameshek that ITP in a young woman should be considered as a possible prodrome of SLE.

In view of these considerations, the occurrence of ITP in a young female whose mother was known to have SLE was considered to be of particular interest. This report is concerned with a description of these cases and a discussion of some of the implications.

### CASE REPORTS

*Case 1.* M.R., a 35-year-old negro female was in good health until 1951 when she developed poliomyelitis. She recovered completely from transient paralysis of all four extremities. On May 7, 1954, she had a hemorrhoidectomy followed by profuse bleeding from the mouth, nose, vagina, and rectum. A diagnosis of ITP was made when her platelet count was found to be zero. She was treated with transfusions, steroids, and finally a splenectomy was done. The bleeding was controlled after the splenectomy, but she developed an acute psychosis which was considered to be a result of the steroid therapy. She was transferred to a mental hospital on August 20, 1954, where she improved over the next few weeks, and was discharged.

She was again admitted to the hospital on February 8, 1959, with a recurrence of bleeding from the nose, mouth, and vagina. Her platelet counts were 5000/mm.$^3$ on admission and 2500/mm.$^3$ 3 days later. An LE cell preparation was negative. Bone marrow examination revealed an abundant number of megakaryocytes with occasional aberrant forms such as relatively agranular cytoplasm and absence of platelet buds with an apparent increase in immature forms. Steroids were not used and the platelet count returned to normal levels as the bleeding ceased over a one-week period.

She was first seen in the Shiffman Clinic January 14, 1960, because of severe bleeding from the mouth and nose following a sore throat four days before. A platelet count done on January 18, 1960, was 182,000 and an LE cell preparation was negative. The sedimentation rate was 75 mm/hr., hemoglobin 9.5 gm. per 100 ml. and a Coombs' test was positive. Total bilirubin was 0.9 mg. per 100 ml. with 0.2 mg. direct. The reticulocyte count was 4.8 per cent.

She refused hospitalization initially, but finally was admitted to Sinai Hospital of Detroit for fur-

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Doctor Kopmeyer was formerly Resident in Medicine, Sinai Hospital of Detroit and the Shiffman Clinic.

ther evaluation on May 9, 1960, at which time she was asymptomatic. At this time, the Coombs' test was negative and the hemoglobin was 13 gm. per 100 ml. The sedimentation rate was 7 mm/hr. Total bilirubin was 1.4 mg. per 100 ml. with no direct bilirubin. The platelet count was 210,000/mm.$^3$ Hemoglobin electrophoresis revealed AA hemoglobin. The WBC was 13,400 with 69 per cent PMNs, 14 per cent lymphocytes, 10 per cent atypical lymphocytes, 5 per cent monocytes, and 2 per cent eosinophiles. The Lee-White clotting time and bleeding time were both 6½ minutes, and clot retraction was complete in 3 hours. LE cell preparations were again negative and serum protein electrophoresis was within normal limits.

She was again admitted to the hospital on January 3, 1962, because of spontaneous bleeding from her mouth of one day's duration. There were no antecedent symptoms, history of trauma, or drug ingestion.

PHYSICAL EXAMINATION: Vital signs were normal. A subconjunctival hemorrhage was present in the right eye. Petechiae were present over the lips, gums, uvula, and legs. There was a large clot present in the right faucial tonsillar fossa. A few pea sized non-tender cervical lymph nodes were palpable as were several slightly larger axillary nodes. Abdominal examination was negative except for a well-healed left upper quadrant splenectomy scar.

LABORATORY STUDIES: The hemoglobin was 12.5 gm. per 100 ml. but marked anisocytosis, poikilocytosis, hypochromasia, polychromasia, and target cells were noted on the peripheral blood smear. A platelet count done the day after admission, was 116,000/mm.$^3$ The WBC was 7500 with a normal differential. LE cell preparations were negative. The sedimentation rate was 62, 53, and 39 mm/hr. on three occasions. Bone marrow examination showed generalized hyperplasia of all elements and iron deficiency. The LE precipitin test was reported as suspicious the first time but was negative on a repeat study. The VDRL and Coombs' test were negative. A latex fixation test was positive. The blood urea nitrogen, thymol turbidity, cephalin cholesterol flocculation, serum iron and iron binding capacity, serum bilirubin, C-reactive protein, and heterophile agglutination were all within normal limits. The serum was negative for cryoglobulins. Serum protein electrophoresis was as follows: albumin 3.57 gm. per 100 ml., alpha-1 globulin 0.18 gm. per 100 ml., alpha-2 globulin 0.36 gm. per 100 ml., beta globulin 0.61 gm. per 100 ml., and gamma globulin 1.76 gm. per 100 ml. A Rumple-Leeds test was positive on the day of admission but negative thereafter. Stool guaiac determinations were positive initially but were negative after the first few days. Chest x-ray revealed minimal left pleural scarring. An intravenous pyelogram, upper GI series, barium enema, and sigmoidoscopy were all negative.

HOSPITAL COURSE: The patient improved rapidly, manifesting no further bleeding after coming into the hospital. She was treated with ferrous sulfate and discharged to be followed in the Out-Patient Department. She has had a hemoglobin consistently in the range of 9 gm. per 100 ml. and her blood smear appears hypochronic. Stool guaiacs are negative and there is no abnormality of the menses. Her sedimentation rate was 35 mm/hr. when last determined. She is asymptomatic except for occasional frontal headaches.

*Case 2.* A.B. (mother of M.R.), a 57-year-old negro female was first seen in the Shiffman Clinic in June, 1956, complaining of a recurrent rash on her face and forearms. There was a two-year history of aching in the fingers, arms, and legs. Physical examination was negative, and her laboratory results: CBC, urinalysis, and serology were also negative except for a hemoglobin of 10 gm. per 100 ml.

In August, 1956, a positive Kahn was reported. Because of the positive serology the patient was given a course of treatment with penicillin.

She was admitted to Sinai Hospital of Detroit on May 7, 1959, because of sudden painful swelling of the left leg. Physical findings were consistent with a deep thrombophlebitis of the left calf and she was treated with anticoagulants. Because of persistent fever, hypergammaglobulinemia, anemia, and positive serologic tests for syphilis, LE cell preparations were obtained and were found to be positive. She received a brief course of prednisone therapy and was discharged.

She was readmitted September 24, 1959, because of fatigue, fever, and pyuria. She had been treated in the Clinic for a urinary tract infection in the preceding two months. Here urine on admission showed 4+ proteinuria and numerous white blood cells. Her BUN, which was 32 mg. per 100 ml., rose to 77 mg. per 100 ml., and then gradually returned to normal levels over the next two months. Two renal biopsy attempts were unsuccessful.

She was treated with antibiotics and large doses of prednisone and improved gradually. Her course was marked by the development of an acute psychotic episode thought to be related to high doses of steroids. She was finally discharged November 25, 1959, on 20 mg. per day of prednisone.

She has continued to do well on decreasing doses of steroids. Her current medications consist of prednisone, 5 mg. daily; hydroxychloroquine, 400 mg. daily; and sodium salicylate, 2.4 gm. daily. Her only complaint is pain and stiffness in the left knee in cold weather. Her LE cell preparations have been consistently positive. Hemoglobin is 14.5 gm. per 100 ml., and serum protein electrophoresis when last done showed the following results: albumin 5.85 gm. per 100 ml., alpha-1 globulin 0.14 gm. per 100 ml., alpha-2 globulin 0.21 gm. per 100 ml., beta globulin 0.68 per 100 ml., and gamma globulin 1.32 gm. per 100 ml.

## DISCUSSION

Rabinowitz and Dameshek[3] reviewed their experience with SLE developing after ITP and found that of 51 cases of ITP subjected to splenectomy, 31.4 per cent had manifestations of SLE other than thrombocytopenic purpura and 15.7 per cent were considered to have definite SLE. In a considerable percentage of their cases, there were histologic lesions of the "onion skin" periarteriolar fibrosis type in the excised spleens. Although somewhat controversial, the presence of well-marked splenic periarteriolar fibrosis is generally accepted as a diagnostic criterion of SLE. In fact, this finding in itself was the basis for a diagnosis of SLE in 3 of the "definite" cases of SLE reported by Rabinowitz and Dameshek. In addition to the histologic changes in the spleen, they consider the presence of discoid lupus, a positive LE cell test, or wire loop lesions in the kidney as "diagnostic manifestations" of SLE which, while not diagnostic in itself, should raise a strong suspicion of SLE. Unfortunately, the spleen sections from Case 1 were not available for review.

Other areas where the subject of "preclinical" SLE has been explored have been in investigations of familial SLE and in studies of asymptomatic relatives of SLE patients. The familial occurrence of SLE has already been mentioned. Studies of relatives of patients with SLE, however, appear even more fruitful so far as providing an explanation of the predisposing factors and perhaps the ultimate pathogenesis of the condition. Larson and Leonhardt[4] described definite SLE in 3, marked hypergammaglobulinemia in 1, and moderate hypergammaglobulinemia in 3 of 14 siblings. In addition, they report identical twins, one of whom had SLE while the other asymptomatic sister manifested only hypergammaglobulinemia. It is their feeling that several of their cases of SLE probably developed against a background of hypergammaglobulinemia. Their findings, plus reports of the familial occurrence of agammaglobulinemia, appear to favor some genetic mechanism which determines the potential of an individual to develop gammaglobulins (or possibly antibody gamma globulin).

Studies of the familial occurrence of the rheumatoid factor also seem to support this apparent abnormality in production of gammaglobulin as a factor in the pathogenesis of "collagen disorders." Kunkel[5] reports 4 families whose members had acquired agammaglobulinemia with one or both parents showing positive serologic tests for rheumatoid arthritis. He also described 2 other families in which SLE was found in relatives of patients with agammaglobulinemia. It is of interest to note that while serum protein electrophoretic partition was previously normal in Case 1, the most recent studies show at least a borderline elevation in gamma globulins. The mother of the patient (Case 2), while showing hypergammaglobulinemia early, now has normal gamma globulin. This is consistent with the findings of Pollak that steroid treated cases of SLE tend to have a return of their protein electrophoretic pattern toward normal.

The LE cell phenomenon is produced by a particular gamma globulin, so called LE cell factor, which is capable of reacting with a nucleoprotein (desoxyribosenucleic acid and histone being required). In addition to this factor, patients with SLE are known to have other nuclear reactive gamma globulins in their serum which react with pure desoxyribosenucleic acid, with histone, or with a histone and DNA free extract of nuclei. Amounts of these individual factors vary, so that a serum may possibly contain few or none of the factors responsible for the LE cell phenomenon but still have appreciable amounts of other antinuclear factors. Thus, a test for many antinuclear factors, as described by Mandema et al[6] might be more sensitive for the diagnosis of SLE than would be a test for a single factor (the LE cell factor). Their investigations suggested that if a certain minimum titer of antinuclear factors was required (1:4 or greater) before being called positive, the result was not only a more sensitive, but also a more specific test than the LE cell test.

Using this criterion of positivity, 131 of 151 sera from patients with SLE were found to contain anti-

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nuclear factors, while only 1 of 90 control sera from asymptomatic subjects or patients with diseases unrelated to SLE was positive for antinuclear factors. In 24 of 50 relatives of patients with SLE, however, antinuclear factors were present in the serum. This suggests again that the tendency to develop antinuclear factors is hereditary, and if these factors are involved in the pathogenesis of SLE, then at least a mechanism for the occurrence of familial SLE can be postulated.

It seems more likely that a basic genetically determined disturbance in gamma globulin synthesis would be etiologically important in the development of SLE than would the mere placental transfer of maternal antinuclear material to the fetus. Reports of the placental transmission of the LE cell factor[7,8] have emphasized that the resulting LE cell phenomenon in the baby was only temporary and was not associated with clinical manifestations, except in the case reported by Nathan and Snapper.[8] In this instance, the child was thrombocytopenic for 1 week and platelet antibodies as well as LE cell factor were demonstrated in both the mother and child.

It would appear then that placental transmission of antinuclear factors is merely part of the normal passive transfer of antibodies to the newborn who is unable to synthesize gamma globulins. If SLE is to later develop in the child, it will probably be related to the individual's inherited gamma globulin production potentialities.

In the cases herein reported, certain features are of interest. The occurrence of ITP in itself should raise a strong suspicion of SLE, especially in a patient who on one occasion demonstrated a positive Coombs' test and suggestive evidence of hemolysis. It should be pointed out in Case 1 that during the last 2 bleeding episodes, definite thrombocytopenia was not present. Thus, the patient may have had non-thrombocytopenic purpura (although there was a 1- to 4-day delay in obtaining platelet counts). Even non-thrombocytopenic purpura, however, along with a consistently elevated sedimentation rate, borderline gamma globulin elevation, iron resistant anemia without evidence of blood loss, slight lymphadenopathy, and a mother with SLE, suggest that the basic disorder in this patient may well prove to be SLE.

In an effort to further relate the disease processes in the patient and her mother, samples of their sera have been analysed for antinuclear factors, as described above. Both showed identical titers of 1:4096. This would seem to be further supporting evidence for the possible existence of SLE in the daughter as well as her mother.

## SUMMARY

Cases of ITP in a young female and SLE in her mother are presented. The familial occurrence of SLE and the relationship of ITP to SLE are discussed. Abnormalities in serum gamma globulins and the occurrence of antinuclear factors in asymptomatic relatives of patients with SLE are emphasized as possible pathogenetic mechanisms of disease. The occurrence of slight hypergammaglobulinemia, ITP, and antinuclear factors in Case 1 suggest that the basic disorder may yet prove to be SLE.

## ACKNOWLEDGMENTS

Serum antinuclear factor determinations were performed at Presbyterian-St. Luke's Hospital, Chicago, through the courtesy of Dr. Victor E. Pollak. The author gratefully acknowledges the help and advice of Dr. J. Edward Berk.

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# STUDY PESTICIDE EFFECTS

Part of a national study on the long range effects of pesticides on humans will take place in Berrien County, according to Douglas Fryer, M.D., director of the Michigan Department of Health Division of Special Medical Services.

The study will be part of a five-year project conducted by MDH, the Barrien County Health Department at Michigan State University.

Doctor Fryer explains that the study is intended to determine the effect of pesticides on the health of the people by monitoring pesticide levels in people and the environment, and then relating this information to the incidence of disease through comprehensive studies of selected groups.

An estimated 20,000,000 children in this country still have not been immunized against measles—but thousands of them are getting the protection in Michigan during the MSMS Measles Campaign, carried out with the excellent cooperation of the county medical societies. "Take your child to your family doctor" has been the dominate message. (See article on Page 291 for further information.)

# MSMS To Conduct Clinical Programs in Four Cities

## *Spring PG Activities Offered In 20 Michigan Communities*

In an effort to expand its educational program for MSMS members, the Postgraduate Medical Education Committee will offer afternoon hospital clinical programs in four communities this spring, in addition to evening lectures in 16 other cities.

All MSMS members living close to the four-area clinical conferences are invited to attend the hospital program and the after-dinner presentation at the host county medical society meeting.

These expanded, afternoon-evening programs will be at:

**PORT HURON, MAY 11**
**MIDLAND, MAY 13**
**KALAMAZOO, MAY 20**
**MARQUETTE, MAY 20**

Teams of outstanding medical educators from the two Michigan schools of medicine have been recruited for the four afternoon-evening pilot programs. The committee plans to offer the same type of programs in other communities in the fall.

The usual MSMS Postgraduate Medical Education lectures will be continued also at the county medical society meetings at Alpena, April 22; Battle Creek, May 4; Cadillac, May 19; Grayling, April 29; Jackson, May 18; Lansing, May 18; Muskegon, May 21; Niles, April 20; Petoskey, April 8; and in the Upper Peninsula at Escanaba, May 18; Houghton-Calumet, May 17; Iron Mountain, May 19; Ironwood, May 18; Manistique, noon on May 18; Menominee, May 19; and Sault Ste. Marie, May 17.

### PORT HURON PROGRAM

At Mercy Hospital, 2 p.m., a Clinical program will be given by Richard J. Bing, M.D., and Anthony C. Nolke, M.D., both of Wayne State University; E. Richard Harrell, Jr., M.D., J. Robert Willson, M.D., and Walter P. Work, M.D., all of University of Michigan; with the evening program by Doctors Harrell and Work.

### MARQUETTE PROGRAM

At St. Luke's Hospital, 2 p.m., a Clinical program with Wm. N. Hubbard, Jr., M.D., John R. G. Gosling, M.D., both of U-M, and F. A. Arcari, M.D., and Melvin L. Selzer, M.D., both of WSU; with an evening program by Doctors Arcari and Selzer.

### KALAMAZOO PROGRAM

At Bronson Hospital, 2 p.m., a Clinical program with Muir Clapper, M.D., Reed M. Nesbit, M.D., William B. Taylor, M.D., James L. Wilson, M.D., and Walter P. Work, M.D., all of University of Michigan; and Alan Thal, M.D., Wayne State; evening program by Doctors Nesbit, Thal and Work.

### MIDLAND PROGRAM

At Midland Hospital, 2 p. m., a Clinical program with Carl E. Badgley, M.D., Arthur C. Curtis, M.D., F. Bruce Fralick, M.D., Reed M. Nesbit, M.D., William D. Robinson, M.D., John M. Sheldon, M.D., Harry A. Towsley, M.D., Earl F. Wolfman, Jr., M.D., and Walter P. Work, M.D., all of University of Michigan; evening program by Doctor Robinson.

## WARD LAUDS COVER

The cover of the January issue of Michigan Medicine with the striking photograph of the Lincoln Memorial and the Lincoln quotation, "You cannot help men permanently by doing for them what they could and should do for themselves," caught the eye of AMA President Donovan F. Ward, M.D. In part, he wrote to Michigan Medicine:

"Not only do I appreciate the photo of the great Lincoln, but also the notable quote which is so apropos at this time. Believe me, it will be used in my future talks."

# Mott Center Hosts Pediatric Symposium

The Second Annual Pediatric Symposium will be sponsored by the C. S. Mott Foundation Children's Health Center at Flint, May 5 at the Center. The topic this year will be "The Adolescent."

The Center reports that guest speakers will include Doctors Roswell Gallagher, Milton J. Senn, Fritz Redl, and James G. Hughes. Other participants will be Drs. Harold L. Wright, Willard Hendrickson, Robert E. Anderson, and William Nicholls, all of Flint.

Registrations will begin at 8:15 a.m., and reservations may be sent to Cecil Bendush, M.D., Chairman, C. S. Mott Foundation Children's Health Center, 806 West Sixth Avenue, Flint, Michigan 48503.

# Eldercare Pushed

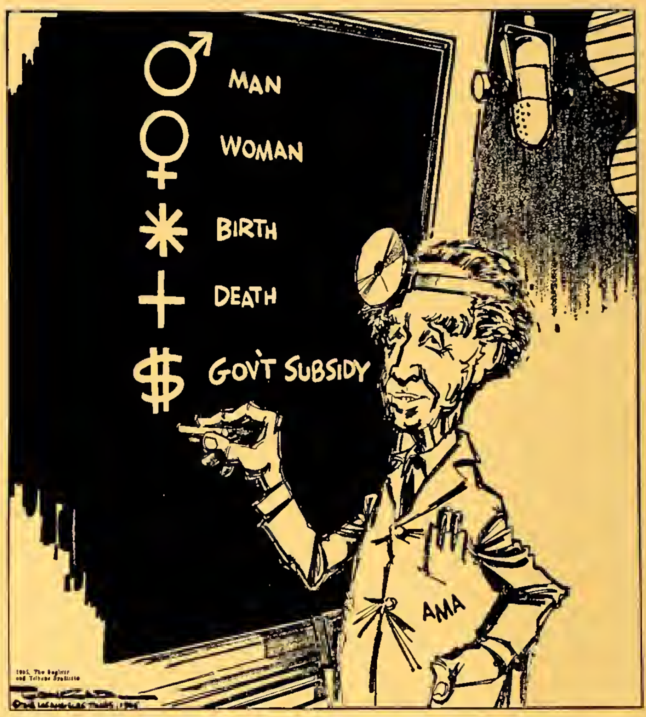
Every county medical society and thousands of Michigan physicians participated during March in the major effort to urge the Congress to adopt the AMA Eldercare bill.

Efforts to sway public opinion and political decisions must be continued. Each county society officer and committee and each physician is urged to continue this vital educational activity.

AMA and MSMS officials express their sincere appreciation for the magnitude of the Michigan effort to oppose the King-Anderson social-security scheme.

Reports were received almost every day during March at the MSMS headquarters about special efforts by the county societies. Speakers Bureaus, Radio, TV and Newspaper Promotion. Letters to the Congressmen. Distribution of Literature. Strategy Sessions et al.

Veteran political observers were amazed during March as public sentiment grew for Eldercare. Seldom has any proposal caught the support of the general public so quickly.



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GREAT MOMENTS IN MEDICARE

## Drug Product Changes Up in '64

Physicians and pharmacists hoping restrictions on new drug introductions would relieve their drug information problems are due for a shock.

Although only 463 new trade-named pharmaceuticals were introduced in 1964, compared with 576 in 1963 and 739 in 1962, the year set a new high in total pharmaceutical marketing activity. The answer to this paradox is found in the seldom considered area of product changes.

New dosage forms and strengths, new formulations, discontinued products and changes in trade names, manufacturers and packages have numbered 400 to 500 items per year since the late 1950s. In 1963 these changes jumped up 32 per cent from the previous year and in 1964 skyrocketed to 846 items, up 90 per cent from the 1960-62 average.

Adding these product changes, the new products introduced and additional forms or strengths announced with new products creates a pharmaceutical marketing figure which reflects the activity of the American drug industry as it met the challenge of restricted new drug introduction, according to Wm. C. Felter, publisher of pharm-Index pharmaceutical reference, Portland, Oregon.

## *Unethical to Use Rx Blanks with Ads*

"It is unethical for physicians to use prescription blanks with the name of a pharmacy printed thereon."

So states the AMA Judicial Council.

The AMA statement was requested by MSMS. The MSMS Council had raised the question with the 1964 House of Delegates and recommended then that the AMA Judicial Council be requested to render an opinion regarding the ethical use of prescription blanks containing printed advertising of a pharmacy or drug store. The House concurred.

## Medical, Dental Skiers Hear Lecturers Too

About 125 doctors and dentists registered for the 5th annual meeting of the Canadian-American Medical and Dental Ski Association at Boyne Highlands, Harbor Springs. The Society re-elected J. Hall, M.D., Sault Ste. Marie, Ontario, President; D. Conley, M.D., Marquette, President-Elect; G. W. Mullin, D.D.S., Sault Ste. Marie; Vice-President, Wm. L. McCullough, M.D., Petoskey, Secretary, and T. J. Trapasso, M.D., Sault Ste. Marie, Treasurer.

The following topics were presented by the speakers: "Dupuytron's Contracture," Robert J. Larson, M.D.; "Instrumentation of Spring for Fractures, Dislocations and Scoliosis," Hugh L. Sulfridge, M.D.; "Radiation Therapy in a Community Hospital," Nikolas J. Theisen, M.D.; "Informed Consent, What Is It and What It Means to the Medical and Dental Practitioner," D. Robb, LL.B.; and "Equilibration Restoration and Your General Health," W. Bruce Kane, D.D.S.

# *Officers Hear Centennial Plans*

"At the MSMS Centennial observance in September, we will consider the position of our profession today in the light of both its scientific and professional attributes and we will lay down guidelines for future action which will best permit us to continue to serve the people with the best medical care in the world."

So declared C. Allen Payne, M.D., Grand Rapids, Centennial Session General Chairman, in his address at the 1965 MSMS Officers Conference at Grand Rapids, March 25. More than 100 MSMS and county society officers participated in the one-day, fast-moving program, formerly known as the County Secretaries-Public Relations Seminar.

Doctor Payne reported to the officers that "The Centennial events will not limit ourselves to reveling in the glories of yesterday, for the past is but a prologue." In this light, Doctor Payne pointed out that "The skills which our hands enjoy come from widely-diverse disciplines and the projection of the services which our hands can render requires the contributions of many minds and hands."

The morning portion of the Officers Conference dealt with state and federal legislation; the luncheon featured awards and an address; and the afternoon focused on the aims of the Centennial and suggested many activities that county society officers can carry out on the local level. The luncheon address on "The Role of Medicine in Society" was presented by Samuel R. Sherman, M.D., Past President of the California Medical Association.

Doctor Payne stressed the importance that the MSMS Centennial activities look ahead by building on the past 100 years of service. In his opening remarks, he declared, "From our present advantageous position we can scan the past and on the basis of that review make some reasonably good guesses about the future. Indeed, on the basis of our experiences we would be remiss if we did not plan for the future." Doctor Payne added:

"If we are to truly recognize the contribution of our colleagues during the past century we would do them an ill favor and incur damage to our own self regard if we did not at the same time give full credit to others who have served many, perhaps even better than we."

This set the stage for detailed presentations to the Seminar participants about each of the Centennial days. The leaders for the various days outlined their plans. Doctor Payne suggested that we will consider the whole man with the clergy . . . recognize the contributions that business, industry and communications have made . . . consider the futures that science and scientists offer . . . note the balance that must hold between the roles of voluntaryism and government . . . and strive to plan among ourselves for the potential that exists if we truly work together."

Commentary by the various chairmen, guest speakers, and visuals followed to tell the county officers more about the MSMS plans for:

**Sunday, Sept. 19**
*Medicine and Religion Day*
**Monday, Sept. 20**
*Medicine and Business, Industry and Communications Day*
**Tuesday, Sept. 21**
*Medicine and Medical Organizational Day*
**Wednesday, Sept. 22**
*Medicine and Science Day*
**Thursday, Sept. 23**
*Medicine and Voluntary Health Day*
**Friday, Sept. 24**
*Medicine and Government Day*

The many speakers who explained the objectives and plans for the Centennial Session all stressed the important part that "must" be played by each individual member and each county medical society.

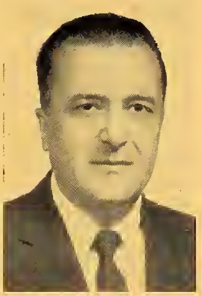
Co-Chairmen for the Seminar were R. A. Frary, M.D., Monroe, as Chairman of the County Secretaries Organization, and R. W. Teed, M.D., Ann Arbor, Chairman of the MSMS Public Relations Committee.

**WATCH FOR MAY ISSUE**

**The May issue of Michigan Medicine will contain further reports on the 1965 Officers Conference. All or a portion of the awards luncheon address will be carried, along with some photographs. Watch for the May issue.**

BRUSH

FALLS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## Four Michigan Physicians Cited

Four Michigan physicians—now serving as presidents of national medical organizations—were honored March 25 at the Michigan State Medical Society Officers Conference.

The handsome "President's Award" was presented these men "In recognition and grateful appreciation for distinguished service to Medicine as President of ——."

Cited by MSMS were Brock E. Brush, M.D., Detroit, President of the American Geriatrics Society; H. A. Towsley, M.D., Ann Arbor, President of the American Academy of Pediatrics; D. Emerick Szilagyi, M.D., Detroit, President of the International Cardiovascular Society, and Harold F. Falls, M.D., Ann Arbor, President of the National Medical Foundation for Eye Care.

Ralph S. Steffe, M.D., left, of Flint, Trustee of the Clara Elizabeth Fund, confers at the Maternal Health Conference with John Rock, M.D., professor of medicine, emeritus, Harvard University, the featured speaker at the banquet program held in Flint. (Flint Journal Photo)

# Maternal Health Conference Hears Noted Doctor Rock

MSMS members participating in the Fourth Annual Michigan Conference on Maternal and Perinatal Welfare at Flint, March 11-12, heard John Rock, M.D., Harvard professor emeritus, declare:

"What causes me increasing concern about birth-control pills is that most of the confusion surrounding the pills seems to me to be attributable to the wishful thinkers who feel obliged to condemn every reasonable method of solving our lethal growth rates throughout the world; only continence is offered."

A world authority in this field, Doctor Rock continued, "This includes the method of periodic continence or so-called Rhythm, which is notoriously unacceptable, for too many couples have found it undependable and too often destructive of family happiness."

The 1965 Conference—moved this year from Gull Lake to Flint—was co-sponsored by the MSMS Maternal Health Committee, the Michigan Department of Health and the Clara Elizabeth Fund of Flint. Recognized authorities from Michigan, New York, Massachusetts and Illinois appeared on the program.

Speaking at the banquet about "The Value and Hazards of the Progestins," Doctor Rock made these strong statements in conclusion. He enumerated the following:

"1. The pills stop ovulation, if taken as prescribed."

"2. The pills in no way act as an abortifacient." ("In no way will the pills, if taken during pregnancy, cause an abortion.")

"3. The pills in no way act as a condom to preventing spermatozoa from entering the womb, or by killing them."

"4. The pills are simply imitative of early pregnancy, and though they may give rise to a mild unpleasantness similar to that of pregnancy, they are not to be considered dangerous, particularly in contrast to a pregnancy in the same woman." Doctor Rock pointed out "that intensive efforts over a 10-year period have failed to establish any relationship, except possibly a favorable one, between the pills and cancer of the female organs."

Doctor Rock made some comments about the role of the Food and Drug Administration, by stressing that "The FDA characteristically proceeds with the utmost caution, regardless of whether such an extreme is pharmacologically justified, simply because it functions in a political atmosphere, and so is particularly sensitive to public apprehensions, warranted or not, and to the opinions effected by them."

## In Brief:

MARQUETTE—The annual Upper Peninsula Medical Society meeting will be held in Marquette this year, on June 11-12. More details about the program will be reported in the next Michigan Medicine by the Society president, W. H. Huron, M.D., Iron Mountain.

* * *

CHICAGO—Oscar D. Stryker, M.D., Mt. Clemens, Chairman of the MSMS Public Health Committee, will represent MSMS at the Second AMA Congress on Environmental Health Problems.

* * *

LANSING—George Sherman, M.D., Lansing, has been named to the Michigan Pesticide Advisory Committee, organized "to make sure the public and other interests are properly safeguarded."

* * *

CHICAGO—A multi-lingual surgeon is the first AMA international field representative. He is Virgil T. (Jack) DeVault, M.D., former associate secretary-general of the International College of Surgeons. Doctor DeVault will spend much of his time with members of the medical profession in other countries. He will discuss patient care and other matters of professional interest with members of organized medical groups, and will arrange AMA assistance when it is practicable, needed and wanted.

* * *

BETHESDA, MD.—Alcoholics, particularly those with the most severe forms of the disease, are increasing among state mental hospitals admissions, according to Stanley F. Yolles, M.D., Director of the National Institute of Mental Health. One in seven newly admitted patients is an alcoholic, an 18 per cent rise in 10 years.

* * *

MUSKEGON—Donald Fairfield is the new executive secretary of the Muskegon County Medical Society, selected to succeed Mrs. Lucy M. Bartlett, who has retired after 18 years of outstanding service. Mr. Fairfield also is the credit manager at Hackley Hospital.

# MSMS Centennial Series: 1957, 1958

## *MCI Telecasts, Seal of Assurance in the Spotlight*

*Leading up to the MSMS Centennial in 1965,* THE JOURNAL *is printing a series of articles by William J. Stapleton, Jr., M.D., Detroit, who is the MSMS Historian. This series began in the September, 1963, number of* THE JOURNAL *and will continue through August, 1965.*

## 1957

Before I give the digest for the year's work, I would like to say something about my good friend, Doctor Arch Walls. If he had not appointed me to the Editorial Board of the Detroit Medical News while he was President of the Wayne County Medical Society, I would not be writing this piece. So to this big man physically, morally, mentally, and medically, I owe a great debt of gratitude. (Owing to ill health, Arch left Michigan and is now living at 225 East Idaho Street, Kalispell, Montana 59901. Why not send him a card, or drop him a note?)

During his presidency of the MSMS, he was especially active in "Operation Armor," an all-out effort to get at least 75 per cent of Michigan's residents immunized against polio and other diseases.

* * *

A SPECIAL SESSION of the House of Delegates was held on April 27, to take steps to strengthen Blue Cross-Blue Shield in the eyes of the public. The MSMS Executive Committee then followed through on a market opinion survey regarding the people's wants in medical prepayment. The Detroit News and the Detroit Times (total circulation 1,100,000) published the MSMS Survey questionnaire July 14.

The IBM tabulation of the returned questionnaires was completed by August 16. The report was to contain an analysis of (1) the survey of doctor opinion regarding Blue Shield policies and administration, (2) the survey of the wants of both the lay public and the medical profession, and (3) the collation of existing data on the medical insurance needs of the public.

The Author
WILLIAM J. STAPLETON, JR.
M.D.
MSMS Historian

**Arch Walls, M.D.**
**MSMS President 1956-57**

**George W. Slagle, M.D.**
**MSMS President 1957-58**

The MSMS survey of health care revealed that (1) 81 per cent of the people of Michigan have some type of health insurance; (2) more than twice as many insured people are covered by Blue Shield in Michigan than by all other health insurance plans combined; (3) people want x-ray services, either in doctors' offices, or outpatient departments of hospitals, covered in their policies, and (4) the doctors reported that a great majority of Blue Cross-Blue Shield subscribers did not understand their policies.

Chairman Otto O. Beck, M.D., reported that 450 MSMS members had contributed the sum of $5,095 to underwrite a Beaumont Memorial deficit.

* * *

THE 1957 MICHIGAN Clinical Institute featured a color television broadcast of a live heart operation from the Grace Hospital in Detroit. Stacks of mail were received that week congratulating the sponsors. Out-state viewers also had an opportunity to see the local history-making event since a kinescope was made of the program for later showing. Sponsors of the kinescope were the MSMS, the Michigan Heart Association, and Smith, Kline, and French Laboratories of Philadelphia.

After nearly two years in the making, "Something Called Epilepsy," a new motion picture produced by the MSMS, was completed. The services of the Michigan Epilepsy Center were used in the filming, and the team approach to diagnosis advocated by the Center was effectively utilized in the story.

* * *

## 1958

1958 was another busy year with special emphasis on education for the doctors. Doctor George

Slagle's contributions to the Michigan State Medical Society for the year included: helping in developing plans for the new Headquarters Building, a survey of health needs of Michigan, development of Blue Shield M-75 program, and his originating of the idea of the Michigan Association of Professions, and the subsequent forming of MAP.

One of the features of the 1958 Michigan Clinical Institute was a public showing of "Blood Vessel Surgery" color live telecast to the public through one or more of Detroit's TV stations.

The peacetime uses of atomic energy as applied to community and individual health problems caught the attention of more than 300 persons who attended the 11th Annual Michigan Rural Health Conference at University of Michigan.

Thirteen new voting members, two associate members, and ten new chapters were welcomed into membership of the Michigan Health Council during 1958. The fourth edition of the Michigan Health Council Directory of Michigan Health Organizations was distributed. This revision—the first since 1955—contained detailed information regarding more than 115 Michigan health organizations.

* * *

A PROGRESS report on the Seal of Assurance plan indicated that about 40 per cent of the total MSMS membership already had enrolled in the Blue Shield contract. The Council adopted the following motion: "Where, in any area of the State, the percentage of returns in the Seal of Assurance is low, the Chairman of the Seal of Assurance Committee is authorized to arrange meetings of members of the MSMS in that area for the purpose of presenting information." The final report of the Seal of Assurance plan indicated that the percentage of MD's participating in the plan had reached a total of 68.8 per cent, as of August 18, 1958.

Special guests at the September meeting of The Council were Architects M. Yamasaki and W. R. Jarret who made a visual presentation of the preliminary plans for the new building.

The Woman's Auxiliary to the MSMS issued Vol. 1, No. 1, of an attractive "Auxilium" in December, 1957. This takes the place of the former Auxiliary News, which was published sporadically over several years.

The Kellogg Foundation granted $324,760 to the University of Michigan to undertake a study of health care. Plans for the most comprehensive study of hospital and medical economics ever made in Michigan were announced by the Kellogg Foundation, the University of Michigan and the Governor's Study Commission on Prepaid Hospital and Medical Care Programs.

The Michigan Maternal Tissue Registry was established at the University of Michigan Medical Center Department of Pathology by the Maternal Health Committee of the MSMS in 1957.

* * *

COURSES FOR MEDICAL assistants opened in Jackson, Lansing, and Pontiac in mid-February in a new inservice training program now being developed by the University of Michigan Extension Service at the request of the Michigan State Medical Assistants Society.

Otto O. Beck, M.D., was elected president of the Beaumont Memorial Foundation at the second annual meeting of members. The Foundation, he said, had ten Life Members ($100) and 300 Sustaining Members ($5 per annum).

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**John A. Cowan, M.D.**, Lansing, "Familial Glaucoma," *Journal American Medical Association*, Vol. 191, No. 7, February 15, 1965.

Recommended Dosage
of Lomotil Liquid
to Control Diarrhea

File: ✓
Diarrhea

LOMOTIL®

| Age | INITIAL LOMOTIL LIQUID DOSAGE* |
|---|---|
| 3-6 mo. | ½ tsp. t.i.d. (3 mg.) |
| 6-12 mo. | ½ tsp. q.i.d. (4 mg.) |
| 1-2 yr. | ½ tsp. 5 times daily (5 mg.) |
| 2-5 yr. | 1 tsp. t.i.d. (6 mg.) |
| 5-8 yr. | 1 tsp. q.i.d. (8 mg.) |
| 8-12 yr. | 1 tsp. 5 times daily (10 mg.) |
| **Adult** | 2 tsp. 5 times daily (20 mg.)<br>(or 2 tablets q.i.d.) |

*Based on 4 cc. per average teaspoonful.
**Note:** After diarrhea is controlled the initial dosage can usually be reduced to meet the requirements of the individual patient.

**LOMOTIL®** TABLETS/LIQUID

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride . . . . . . . . . . . . . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . . . . . . . . . . . . . . . . . . . . . 0.025 mg.

**Precautions**
Lomotil is an exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

**Cautions and Side Effects**
Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

SEARLE *Research in the Service of Medicine*

## Carcinoma

*Continued from Page 257:*

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## AMNIOTIC FLUID

*Continued from Page 260:*

disease, delivery is accomplished at or near term.

5. With mid-zone values, delivery is carried out at 37 to 38 weeks.
6. Upper zone values imply such a bad prognosis that earlier delivery may be justified.

### *Summary:*

As yet, there are no means to prevent Rh sensitization or to neutralize its damaging effects. Determination of the amniotic fluid spectral absorption curve establishes the diagnosis of erythroblastosis fetalis and reflects the fetal prognosis with a high degree of accuracy. Thus far we have not increased fetal salvage by delivery before the 36th week of pregnancy. The best prognosis for the erythroblastotic infant lies in prenatal diagnosis, proper timing of delivery, and prompt pediatric treatment.

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## Sees Hospital Automation Ahead

Max Sadove, M.D., head of the Department of Anesthesiology, School of Medicine of the University of Illinois, contends that automation of hospitals soon will include use of sonic beams to check patients' pulse, blood pressure, etc., and installation of "consoles" in rooms, providing complete services—compressed air, oxygen and vacuum as well as television and radio monitors and outlets for performance of EKG (electrocardiogram) and ECG (electroencephalogram) tests without actually moving the testing equipment into the room.

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**'METHEDRINE'® brand**
**METHAMPHETAMINE**
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**therapy**

Her once unruly appetite is now well tamed with 'Methedrine' (methamphetamine hydrochloride)...an easy way to help control food craving and "hunger pains."

**Side effects:** Insomnia may occur if taken later than 6 hours before retiring. The usual peripheral actions of sympathomimetic amines (vasoconstriction and acceleration of the heart) are minimal and little noticed on low or moderate dosage.

Complete literature available on request from Professional Services Dept. PML.

**Contraindications and precautions:** Should not be used in patients with myocardial degeneration, coronary disease, marked hypertension, hyperthyroidism, insomnia or a sensitivity to ephedrine-like drugs. Moderate hypertension in the obese is not necessarily a contraindication since it may be relieved as the overweight is reduced.

'Methedrine' brand Methamphetamine Hydrochloride: Tablets–5 mg., scored, in bottles of 100 and 1000.

**BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.**

# New broad-spectrum penicillin but without broad-spectrum toxicity[1-10]

no blood dyscrasias
no photosensitivity
no severe gastric disturbances
no pigmentation of teeth
no kidney damage
no accumulation in long bones

PENBRITIN (ampicillin) brings the traditional penicillin advantages to areas of treatment formerly dominated by the tetracyclines and chloramphenicol — urinary and gastrointestinal infections, as well as respiratory infections. But PENBRITIN (ampicillin) *does not cause the toxic disorders* associated with other broad-spectrum antibiotics.[1-10] And highly important: PENBRITIN (ampicillin) *kills* bacteria instead of merely suppressing them.

*Usual dosage:* Adults — 250 mg. every six hours in respiratory infections; 500 mg. every six hours in urinary and gastrointestinal infections (higher doses may be needed in severe infections). Children — (under 13 years, whose weight will not result in a dosage higher than that recommended for adults) 100 mg./Kg./day in divided doses every six or eight hours for moderately severe infections; 200 mg./Kg./day in divided doses every six hours for severe infections.

*Contraindications:* (1) Hypersensitivity to penicillin. (2) Infections by penicillinase-producing staphylococci and other penicillinase-producing organisms.

*Side Effects:* Mild effects, such as skin rashes, diarrhea, nausea and vomiting have occasionally appeared.

*Precautions:* As with other antibiotics, precautions should be taken against gastrointestinal superinfection. To date, safety for use in pregnancy has not been established.

*Supplied:* No. 606 — Each capsule contains 250 mg. of ampicillin. Bottles of 16 and 100.

*References:* 1. Editorial. Brit. M. J. *ii*:223 (July 22) 1961. 2. Rolinson, G. N., and Stevens, S.: Brit. M. J. *ii*:191 (July 22) 1961. 3. Stewart, G. T., *et al.*: Brit. M. J. *ii*:200 (July 22) 1961. 4. Brown, D. M., and Acred, P.: Brit. M. J. *ii*:197 (July 22) 1961. 5. Batchelor, F. R., *et al.*: Nature *183*:257, 1959. 6. Knudsen, E. T., *et al.*: Brit. M. J. *ii*:198 (July 22) 1961. 7. Doyle, F. P., *et al.*: Nature *191*:1091 (Sept. 9) 1961. 8. Acred, P., *et al.*: Brit. J. Pharmacol. *18*:356, 1962. 9. Harrison, P. M., and Stewart, G. T.: Brit. J. Pharmacol. *17*:420, 1961. 10. Editorial. Lancet *ii*:723 (Oct. 5) 1963.

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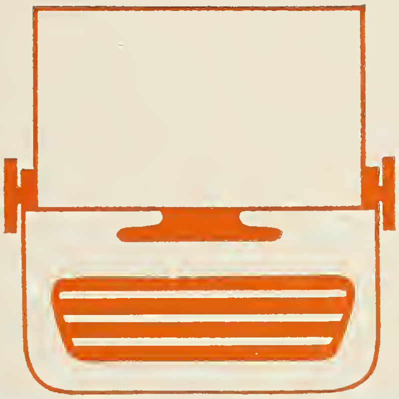
# Doctor and Nurse In a Changing World

R. J. Mason, M.D., Vice Chairman
MSMS Council

In an educated society, progress is change, and progress cannot be stopped. It may be slow or abrupt, it may be insidious or revolutionary, it may be altered or re-directed, but progress always initiates a change. To be unchanging is to become strangled in stagnation.

Thus, in the overall planning for the best medical care of the patient, the medical team of the physician and his good "right hand"—the professional nurse—find themselves in a changing medical world. At the turn of the century the nurse was cast in the role of a "hand maiden" who was "beholden" to the physician. Today, this new "right hand," the professional nurse, is adroit, poised, intelligent, well-schooled and scientifically-trained to execute the exacting duties of the medical team in total patient care. Focusing attention on the team concept was the "First National Conference for Professional Nurses and Physicians" held in Williamsburg, Virginia, in 1964.

Aided by the guide lines enumerated at this National Conference, and encouraged by the forward looking attitude of the AMA Committee on Nursing, the MSMS Liaison Nursing Committee has suggested an expanded list of Nursing Functions which have heretofore not been adequately defined. These definitions, now having been approved by the Council of the Michigan Nursing Association as well as by the Council of MSMS, with proper legal advice, appear on page 295.



## EDITORIAL VIEWS

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# Right Word Is Therapy

By John V. Fopeano, M.D.
Kalamazoo

Perhaps the most underrated agent in the whole realm of useful therapy is the *right word,* said in the right tone of voice at the right time.

The importance of this word is recognized in diplomacy, in the theatre, in education, in advertising, in public relations and most of all in the interpersonal relations within a family.

What miracles are accomplished by those words, "I love you," when properly timed and intoned, and what devastation when omitted!

Medicine says very little about the use of words as therapy. Maybe in times past doctors talked too much and didn't give the patient a chance to tell what was wrong with him. Now doctors may not be saying enough to establish any kind of meaningful communication with their patients.

The victories achieved by sanitation, immunization, surgical techniques, improved nutrition, drugs and electric shock have taken the center of the stage in the medical world. Nowhere in the schedules of benefits paid by insurance companies is there a term that describes the service rendered by a doctor who supplies the right word at the right time. Nor in the texts on current therapy is the right term to be found. "Psychotherapy" is much too formal and cold a term to be used to describe the good will, the warmth, the encouragement, the motivation that can be generated in a patient by the use of the proper word at the right time.

There are many pharmaceuticals, wines, liqueurs, and bartenders' recipes which enjoy considerable reputation as antidepressants, ataractics and tranquilizers, which have the advantages of being conveniently packaged and marketed in a businesslike, highly efficient manner. Of course these have their proper places but they have about them an ersatz quality which make them suspect to the person who is lonely, who questions his own worth, who is looking for a real purpose in life and a motivation for effort. And what conscious person does not have these days? Not in a form dangerous enough to justify the formal services of a psychiatrist or a family counselor, not in a degree serious enough for the self reliant mature person to mention to his doctor.

Nevertheless, the feelings are there and the doctor is in the best position to recognize them and to open the gate to a happier day for his patient.

Providing the right word in such a situation is the art of medicine. It is not happy sympathy. It is not insincere deception to avoid facing realities nor is it a brutal confrontation of the facts stripped of modifying circumstances, which are also part of reality. It is not a display of brilliance to impress the patient with the skill and wisdom of the doctor.

The right word is the one that will help the patient feel that he is worthy of the personal attention and love of someone like a doctor or therapist. It is a word that helps him to understand what has happened to him and helps him to do something sensible to achieve a reasonable goal. It is a word which makes hope seem reasonable.

To provide such a word requires some effort. It is a part of therapy which may be overlooked in concern for the details of examination, surgical procedures, dietary instructions, dosage schedules and drug prescriptions. It may be omitted because the doctor does not know what to say and would rather run the risk of saying nothing than to say the wrong thing. But silence can be a cruel thing that isolates a patient and makes him feel rejected and lost in a unfamiliar strange land where he does not understand the language and can't read the road signs.

Actors, writers, musicians and others who are concerned with communicating spend hours learning to use the right word or the right note at the right time. It does not degrade the healing professions to add this therapeutic agent to their armamentarium. Although the words used must be learned from scientific disciplines and must be based on facts, the timing and tone of voice employed must come from the heart—that wonderful organ that integrates intellect with instinct, intuition and inspiration and often calls the signals for the finest acts of man.

# On Guard!

Arnold Toynbee said: "Civilizations rise or fall on their abilities to respond to a challenge." The same may be said about the professions, because none among them will prevail which is unable to meet its particular challenge to serve society.

Indeed the very concept of professionalism which we all cherish, can be lost. It will be, unless professional people resist the misguided attempts of other segments of today's society to take from the individual professional man his privilege to make decisions, which are:

1. In the patient's best interest.
2. Free of dictation and second guessing from parties outside the professions.
3. Based upon knowledge, skill and dedication to professional principles and standards.

Throughout the history of mankind, freedom has seldom existed, and never for long. In the United States of America our nearly 200 years of freedom is but a fleeting moment in history. Our citizenry must be ever alert to maintain this precious and historically scarce possession in our time!

## COMING IN MAY

In the May issue, J. Robert Willson, M.D., Chairman of the Department of Obstetrics and Gynecology at University of Michigan, reports on the "Physician's Responsibility in Family Planning and Population Control."

C. Jack Hipps, M.D., Ruy Vianna, M.D., and Khalid M. Durrani, M.B., F.R.C.S.(c), of Detroit, report an interesting clinical study comparing Oxyphenbutazone with Enzymes in Rhinoplasty.

Wayne Glas, M.D., and S. M. Baylis, M.D., of the Wayne County Hospital, report on Electromyographic and Skeletal Muscle Relaxant Drugs.

In addition, Leon Ostrander, M.D., reports four most interesting cases with Arthritis and Valvular Heart Disease, and Peter Martin, M.D., Clinical Professor of Psychiatry at Wayne State University's School of Medicine, presents an excellent and authoritative discussion of "Common Sexual Problems in Marriage."

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**Therapeutic effects**

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The initial response is usually maintained without dosage increases; indeed, initial dosage is often reduced for maintenance purposes.

Salicylate or steroid therapy can usually be diminished or, in some instances, eliminated.

Psoriatic arthritis responds in the same way as rheumatoid arthritis but the skin lesions are usually not affected either favorably or adversely by treatment.

**Precautions**

Before prescribing, the physician should obtain a complete history and perform a complete physical and laboratory examination, including a blood count.

The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools.

If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time.

**Side effects**

The most common side effects are nausea, edema and drug rash. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug.

**Contraindications**

These include: edema, hypertension, or danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when other potent chemotherapeutic agents are given concurrently because of the increased possibility of toxic reactions; when the patient cannot be seen regularly; when the patient is senile.

*Note:* The physician should be fully aware of dosage, precautions, side effects and contraindications as contained in the complete prescribing information.

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# OUR STATE SOCIETY

## ADOPT STATEMENT ON FAMILY PLANNING

The following statement, offered by the MSMS Maternal Health Committee, was adopted by The MSMS Council on March 3.

### MSMS Statement on Family Planning

"The current interest in various aspects of family planning and the recognition of the importance of human reproduction, including population control, have put emphasis on the responsibility and need for leadership from the medical profession.

This leadership must manifest itself through counselling with the individual patient in the physician's office and cooperating with organizations whose purposes coincide with, and whose direction is provided by, the medical profession.

"The very personal nature of this advice and counselling in family planning makes it mandatory that consideration be given to the patient's wishes and desires, her ethnic and religious background. The physician or clinic must be prepared to counsel on all the various aspects of family planning, whether in assisting a couple to have a family, or, at the other extreme, in assisting a couple to postpone additions to their family. In the latter regard, expert counselling in the technique of rhythm should be just as readily available as expert advice in the newer forms of family planning."

## You Read It First

—The Michigan Pharmacist in February reprinted from the November issue of MICHIGAN MEDICINE the article about "Some Factors Influencing the Therapeutic Value of a Medicinal Agent" by Martin Barr, Ph.D., Dean of Pharmacy at Wayne State University.

—The Texas State Journal of Medicine in January excerpted a public relations article from the November issue of MICHIGAN MEDICINE.

## MSMS Past President, Louis J. Hirschman, M.D., Dies at Traverse City

Louis J. Hirschman, M.D., President of MSMS in 1928 and a Past President also of the Wayne County Medical Society, died February 23, at Traverse City. He was 86 years old.

A noted proctologist, he practiced in Detroit for 50 years and moved to Traverse City when he retired in 1950.

While in Detroit, he was a Councilor to MSMS before his election as State President. In addition to being President of WCMS, he was editor of the Detroit Medical News at one time. He was a Life Member of both MSMS and WCMS and was the recipient of a MSMS 50-year pin.

Born in Republic, Michigan, Doctor Hirschman received his medical degree from Wayne State University School of Medicine in 1898. He interned at Harper Hospital. He was consulting proctologist to Harper, Jennings, Womens, Childrens, Deaconess, St. Joseph's Mercy and Receiving hospitals, all in Detroit, and in later years to the State Hospital in Traverse City.

Long active in medical affairs, Doctor Hirschman was a founder of the American College of Surgeons, the American Board of Proctology and the Detroit Medical Club.

He served as delegate to the American Medical Association and was a past chairman of the AMA Section on Gastro-enterology and Proctology. Doctor Hirschman was an Honorary Fellow in the Royal Society of Medicine in England and the author of many books and articles on his specialty.

His memberships in medical organizations included the Detroit Academy of Surgery, the Detroit Surgical Club, and he was a Past President of the American Proctologic Society and the Detroit Academy of Medicine.

During World War I he was a Lieutenant Colonel in the Medical AEF in 1917-18 and served in the Reserve since 1918.

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## MEDISCENE

**April 21**—Symposium on Trauma, Holly's Inn (U. S. I-96), Muskegon Heights.

**April 25**—Michigan State Medical Assistants Society Seminar, Michigan Union, Ann Arbor.

**May 13-14**—Michigan Speech and Hearing Association Conference on "Sensory-Motor Aspects of the Speech Mechanism," Kellogg Center.

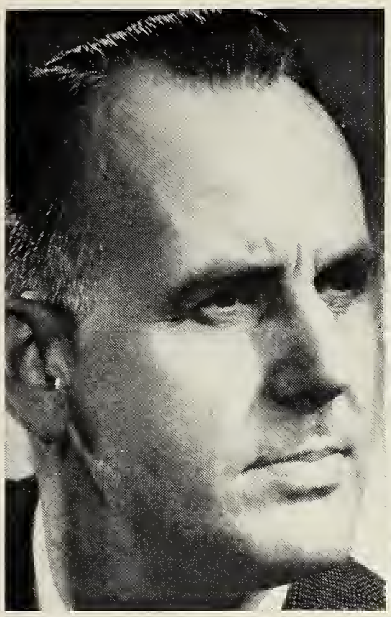
**May 19**—Wayne State Clinical Program and Alumni Reunion Banquet, Sheraton-Cadillac.

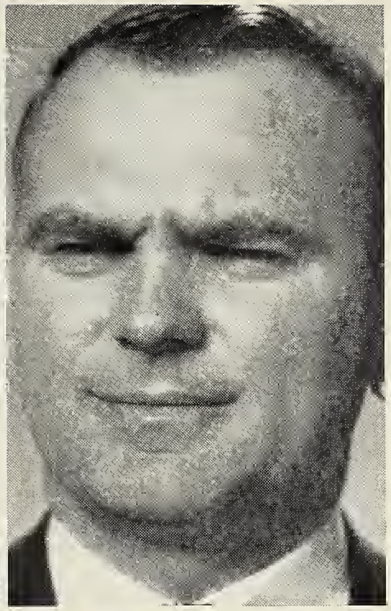
**June 10**—Michigan Orthopaedic Society, summer meeting, Hidden Valley, Gaylord.

**June 11-12**—Upper Peninsula Medical Society, Marquette.

**Sept. 16-19**—American Medical Writers Association, Detroit.

**Sept. 19-24**—MSMS Centennial Session, Cobo Hall and Sheraton-Cadillac Hotel, Detroit.


P. B. Dits—Benton Harbor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# ANCILLARY SECTION

## Children's Symposium In May on "Adolescence"

The 1965 Clinic Days of Children's Hospital of Michigan and the Wayne State University School of Medicine will be held May 20 and 21, at the headquarters of the Wayne County Medical Society, 1010 Antietam Street, Detroit.

The topic for the two-day symposium is "Adolescence." Chairman Louis E. Heideman, M.D., reports that speakers will include: Guilio J. Barbero, M.D., Philadelphia, on "Gastro-Intestinal Illness in Adolescence"; Felix P. Heald, M.D., Washington, D. C., on "Growth, Nutrition and Obesity"; Wilton Krogman, Ph.D., Philadelphia, on "Adolescence—Time of Growth Variability"; Guest speaker at the Banquet: "The Bones Tell of Life and Sudden Death"; Richard Komisaruk, M.D., Detroit; on "Juvenile Delinquency"; Clyde Simson, M.D., Detroit, on "Patterns in Diagnosis of Emotionally Disturbed Children"; Paul V. Wooley, Jr., M.D., Detroit, on "Disease and Pseudodisease in Older Children"; Miss Miriam Buncher, on "Illegitimate Pregnancy": and Carl L. Marburger, Detroit, on "Vocational Guidance, Education and Training."

## J. E. Livesay, M.D., Chairs College of Radiology Board

Jackson E. Livesay, M.D., Flint, is the new chairman of the Board of Chancellors of the American College of Radiology, installed at the annual meeting in Philadelphia.

Doctor Livesay, a fellow and College Councilor from Michigan, is a past speaker of the Michigan State Medical Society House of Delegates from 1954-56.

## GIFT FROM TOWSLEYS TO PROVIDE U-M WITH POSTGRADUATE CENTER

"The gift of $700,000 from the Harry A. and Margaret D. Towsley Foundation will create a facility where a program of continuing education responding to the total health needs of the patient, his family and his community can find expression, thus extending the opportunities for the members of the health team to learn together so that they may more effectively work together."

So stated Medical School Dean W. N. Hubbard, Jr., M.D., and A. C. Kerlikowski, Director of the University Hospital, when the grant was accepted by the U-M Board of Regents.

The gift is for the construction of a medical and health continuing education center to house the administrative staff of the department of postgraduate medicine. The center also will serve as the site for the continuing education programs in medicine and related health sciences.

An auditorium with a seating capacity of 500, a classroom with capacity of 150, and four conference rooms capable of seating 40 to 60 each, will be included, as well as registration and other facilities.

Doctor Towsley is director of the U-M Department of Postgraduate Medicine and also chairman of the MSMS Postgraduate Education Committee.

The proposed new building will be a separate physical structure located on the east side of University Hospital. It will be accessible to patient units of the main hospital, the Women's Hospital, the new Mott Children's Hospital, the outpatient building, and the proposed ambulatory care unit.

The U-M postgraduate medical education program is one of the largest in the country. About 2,500 physicians come to Ann Arbor each year for the 35 courses given by the department. Another 1,800 enroll for courses given by the University in hospitals in about 20 cities throughout the state.

## Select Cobo Hall For '65 Art Exhibit

Cobo Hall will be the site of the Fifth Annual Art Exhibit by Michigan doctors and wives September 21-22-23. The Exhibit will be held in conjunction with the Centennial session of the Michigan State Medical Society

Special efforts are being made to encourage more doctors and wives to enter a work of art in the fall exhibit. Each entrant is limited to four entries. Additional information may be secured from the chairman of the Art exhibit, Mrs. George E. McKeever, 1767 Culver, Dearborn, 48124.

## Plan Auxiliary Convention

Plans are being advanced by three leaders of the Woman's Auxiliary to MSMS for the 1965 Auxiliary Convention in Detroit in September. Left to right, shown during the recent Auxiliary winter meeting at the Whittier Hotel in Detroit, are Mrs. Lowell Redding, Dearborn; Auxiliary President, Mrs. Milton Weed, Detroit; and Mrs. George McKeever, Dearborn, chairman for the Art Show. (Michigan Medicine Photo)

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# Ancillary News -And It's Brief

AMA Past President Edward R. Annis, M.D., will be one of the featured speakers at the 1965 Michigan State Dental Association District Officers Conference in Detroit, May 2. The theme for the annual workshop will be "Political Action by Dentists."

☆ ☆ ☆

The Michigan State University College of Veterinary Medicine has received a $ 596,400 contract to conduct research on the causes of canine leukemia and its possible relationship to the human form of the disease.

☆ ☆ ☆

The Michigan League for Nursing will offer 26 competitive nursing scholarships for 1965 high school graduates, through funds contributed by Michigan Hospital Service, Department of Michigan of the American Legion Auxiliary, Medical Arts of Grand Rapids, and by individuals and foundations.

Scholarship applications must be filed before April 15, 1965. Students should contact their high school principal or counselor or write to Michigan League for Nursing, 51 W. Warren Avenue, Detroit, 48201.

## Offer Rheumatic Fever Desk Reference Cards

All Michigan physicians are strongly urged to send for the revised and completely up-to-date set of "Desk Reference Cards for Rheumatic Fever," now available free from the Michigan Heart Association, 13100 Puritan, Detroit, 48227, or from MSMS.

Sidney E. Chapin, M.D., Chairman, MSMS Cardiac Disease Control Committee, said a phone call or note will be enough to bring any physician the newly prepared set. It consists of 31 four-by-six inch file cards, and includes an index. The cards are held by a fastener so they can be riffled to any one of the 18 sections in which the subject is divided.

They were revised by a special 14-man committee of MHA in cooperation with MSMS, chaired by Frank D. Johnson, M.D., Flint.

Index headings are: Diagnostic Criteria; Prevention and Prophylaxis; Surgery for Rheumatic Heart Disease; Heart Murmurs in Valvular Deformity; Drugs in Rheumatic Fever; Physical Capacity with Heart Disease; Growing Pains; Laboratory Tests in Rheumatic Fever; Public Health Aspects of Rheumatic Fever; The Electrocardiogram; Rheumatic Heart Disease in Pregnancy; The Blood Pressure; The Group A Streptococcus; Skin Manifestations in Rheumatic Fever; The Rheumatic Child in School; Rheumatic Fever vs. Rheumatoid Arthritis; Chorea; Bacterial Endocarditis.

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J. B. BLODGETT

R. V. TAYLOR

# DR. BLODGETT LEADS HEART ASSOCIATION, DR. TAYLOR NEXT

James B. Blodgett, M.D., Detroit, is the new president of the Michigan Heart Association, elected by the Board of Trustees in Detroit, February 27. He succeeds Park W. Willis III, M.D., Ann Arbor.

The Board of Trustees also named Ross V. Taylor, M.D., MSMS Councilor, Jackson, as president-elect.

The Association elected 10 new members to the 40 member Board of Trustees. Of the 10, eight were physicians. They are Gerald A. Drake, M.D., Petoskey; Frederick Epstein, M.D., Ann Arbor; Edward W. Green, M.D., Detroit; Sibley W. Hoobler, Ann Arbor; Frederick B. House, M.D., Ann Arbor; Michael C. Kozonis, M.D., Pontiac; Joseph Preston, M.D., Jackson; and Edward M. Schneider, M.D., Kalamazoo.

It is interesting to note that Doctor Blodgett has a twin brother William H. Blodgett, M.D., who is an orthopedist, and their father, William E. Blodgett, M.D., also an orthopedist, has practiced in Detroit for almost 50 years; while Doctor Taylor has three sons who are physicians and his brother Bowen E. Taylor, M.D., of Lincoln, Nebraska, has just completed a term as President of the Nebraska Heart Association.

DR.E.W.GREEN
DR M.S.HECHT
DR.A.M.STERN
DR.R.MILLER

Among the speakers at the annual Michigan Heart Association Scientific Session, in Detroit, February 27, was this panel on "Heart Disease in Children: Identification and Management." Left to right are Edward W. Green, M.D., Detroit; Manes S. Hecht, M.D., Detroit; Aaron M. Stern, M.D., Moderator, Ann Arbor; Robert Miller, M.D., Chicago; and Gene H. Stollerman, M.D. of Tennessee.

# Medical Assistants In Ann Arbor April 25

Members of the Washtenaw County Medical Assistants Society will handle many of the duties of hosting the Eighth Annual Education Seminar of the Michigan State Medical Assistants Society at Ann Arbor, Sunday, April 25.

Fae Wallace is chairman, assisted by Doris Schilling, Lillian Elliott, Betty Peck, Helen Hughes, Ruth Trimm, Marie Weatherwax and Rowena Richards.

The event will be held at the Michigan Union. The morning program, beginning at 9:45, will offer "Operational Teamwork" by Kenneth K. Shook, D.D.S., Kalamazoo; and "The Eye in Systemic Disease" by F. Bruce Fralick, M.D., Ann Arbor. Luncheon will be at 12:30 p.m. and the afternoon will feature the L. Fernald Foster Lecture on "Modern Concepts of Plastic Surgery" by Reed O. Dingman, M.D., Ann Arbor.

## Call Specialty Leaders

The AMA Board of Trustees has approved a Forum of National Medical Specialty Societies, sponsored by the AMA, to be held early in October 1965, with the expenses of those representing the AMA paid by the Association.

## Ford Foundation to Aid U-M Population Research

The Ford Foundation has given a three million dollar grant for establishment of a population research and training program of university-wide proportions at the University of Michigan.

"The University of Michigan program," said Oscar Harkavy, director of the Foundation's Population Program, "is for a long-range effort to focus the resources of widely divergent academic and professional departments—for example, sociology, public health, psychology, education, obstetrics, and economics—on a coordinated approach to problems of population growth. This grant supports a large university's marshalling of its varied resources to the entire range of population issues."

Michigan plans to expand the activities of its Center for Population Studies, which now conducts basic social research and training, provides fellowships for American and foreign students, and offers assistance to less-developed countries on fertility-regulation programs.

In addition, the university is establishing two new units, a Center for Research and Training in Reproductive Biology, and a Center for Population Planning at the university's School of Public Health.

# WSU Combines Reunion And Research Building Dedication, May 18-19

Two days of special activities—May 18 and 19—are planned for Wayne State University medical alumni.

The combined Clinical Program and Alumni Reunion Banquet, at the Sheraton-Cadillac Hotel, will be held May 19.

Alumni have been invited to plan an extra day in Detroit and attend the May 18th dedication ceremonies for the Medical Research Building, first new structure on the developing medical campus. The ceremonies will include ribbon-cutting at 11:00 a.m., and Honors Convocation highlighted by a symposium on "Horizons in Medical Research," at 1:30 p.m. in the Community Arts Auditorium. Informal tours of the new research facility will be conducted for alumni after the symposium.

Symposium speakers include: Harry Eagle, M.D., Bronx, N. Y., known for investigation in molecular biology; Geoffrey W. Harris, M.D., Oxford, known for work in the field of hypothalamic-pituitary inter-relationships; and Horace W. Magoun, M.D., Los Angeles, known for research in neurology.

The Clinic Day registration will begin at 8:00 a.m. Speakers at the morning sessions include Rosser L. Mainwaring, M.D., Dearborn; Cary P. McCord, M.D., Ann Arbor; Emmanuel A. Friedman, M.D., Chicago; and A. Martin Lerner, M.D., Detroit.

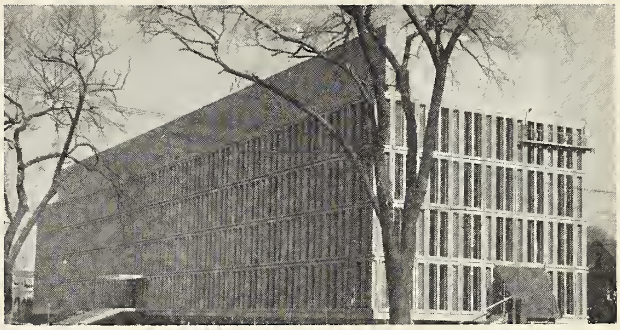
Speakers from the School of Medicine in the afternoon sessions include H. Harrison Sadler, M.D., and Assistant Dean Alexander Walt, M.D., who will conclude the scientific portion of the program. Evening events will consist of a reception for alumni and guests, followed by the annual Alumni Reunion Banquet in the Grand Ballroom at 7:00 p.m.

## Glaucoma Testing Saves 54

At least 54 persons who were gradually losing their sight were saved from impending blindness in 1964 as a result of glaucoma detection programs sponsored by local health departments and the Michigan Department of Health.

The State Department reports that locally sponsored glaucoma detection programs have discovered persons for as little as $20 per case.

The Michigan Department of Social Welfare, reports as of January 1, 1965, there was 1,680 persons in Michigan receiving aid to the blind payments, averaging $81 a month—a total of more than $1.6 million a year, not counting other forms of public assistance and loss of earning power. A total of 241 persons began receiving aid in 1964.



The new WSU Medical Research Building, with 92,000 square feet of floor space, is so designed to be functional and flexible. There are utility outlets every 10 feet the length of the building so that laboratories can be made as small as 200 square feet or as large as 2,000 square feet, depending upon the research needs of the projects that are going on at any given time. In this building there are some classrooms and no office space. Research offices are included in with the space of the laboratories. Total cost of this four-story structure is $3,050,000. Of this amount the Legislature appropriated $2,025,000. The rest was derived from Federal grants and aid.

## Skeletal Disease Symposium Set May 26 in Detroit

The Third Annual Skeletal Disease Symposium will be held at Cobo Hall, May 26, from 9 a.m. to 5 p.m., sponsored by the Neurology department, Wayne State University School of Medicine; Detroit Memorial Hospital Department of Neurology and Physical Medicine and Rehabilitation; and the Muscular Dystrophy Association, Wayne County Chapter. The morning session will deal with the differential diagnosis of muscle disease by (1) microscopic methods, (2) electromyography and motor-sensory conduction methods, (3) biochemical biopsy (serum enzymes) and differential diagnosis by clinical means. The luncheon will be addressed by Ade Milhorat, medical director of the Muscle Disease Institute, New York, on "Research Frontiers in Muscle Disease." The afternoon session will cover inflammatory muscle disease, electron microscopy of muscle, physiological aspects, clinical application of myoelectric currents in paralysed muscle, rehabilitation aspects, and recent concepts regarding muscle tone (alpha and gamma systems).

There is no registration charge. Address all communications to M. K. Newman, M.D., 16861 Wyoming Ave., Detroit 21.

### COMMUNITY HEALTH WEEK

The AMA Board of Trustees has set November 7-13, for the observance of Community Health Week.

# Explains Designations Of Laboratories; List Of Syphilis Tests

*(Editor's Note: The following article from the Michigan Department of Health explains some current health matters that will be of considerable interest to MSMS members.)*

The statutes of Michigan use the terms **registered** and **approved** in referring to public laboratories in Michigan. The relationship between a registered and an approved laboratory is apparently not clearly understood by some Michigan physicians, especially those physicians performing medical examinations for the presence of syphilis, gonorrhea, or chancroid on persons planning to make application for a marriage license.

A **registered** laboratory is defined as a public laboratory making chemical, serological, and/or bacteriological laboratory tests to aid the diagnosis and/or control of communicable diseases. Such public laboratories are required to be registered with the Michigan Department of Health (Act No. 45, Public Acts 1931).

An **approved** laboratory is defined as a laboratory approved by the State Commisioner of Health to perform those laboratory tests necessary to assist in determining the existence or non-existence of syphilis, gonorrhea, or chancroid in persons planning to make application for a license to marry (Act 207, Public Acts 1937), or a laboratory approved by the state department of health to perform a standard serological test for syphilis on samples of blood taken from pregnant women (Act 106, Public Acts 1939). A list of approved laboratories is periodically provided the county clerks of Michigan by the Michigan Department of Health for premarital purposes.

The currently approved list of tests used for the serodiagnosis of syphilis includes the following tests: the VDRL test (tube and slide), the RPCF test, the Kline test, the Kolmer test, and the Mazzini test.[*] It will be observed that the list does not include the Kahn test. The Michigan Department of Health discontinued the Kahn test on February 28, 1961, because of the desirability of employing a cardiolipin antigen test, also because of the difficulty in obtaining standardized Kahn antigen, and because of the lack of a sufficient number of reference laboratories. The Public Health Service Venereal Disease Laboratory has not included the Kahn test in its annual evaluation studies since 1963. Michigan laboratories were notified on June 26, 1964, that the Kahn test would no longer be recog-

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where ischemia causes pain, spasm, ache, intermittent claudication; also coldness, numbness or ulceratio
of extremities.

nized as a standard serologic procedure after January 1, 1965. Thus, laboratories performing the Kahn test as the *sole* serologic test for syphilis after this date could therefore neither be registered nor approved by the Michigan Department of Health.

In general, physicians may be more interested in "approved" Michigan laboratories since these laboratories are listed with the county clerks for premarital purposes. Physicians are therefore urged to be certain that premarital blood specimens are examined in laboratories listed as approved with the various county clerks.

*As of February 15, 1965, the Fluorescent Treponemal Antibody test is performed by the Michigan Department of Health Division of Laboratories, Lansing, as an adjunct to the VDRL and RPCF tests, under the following circumstances:

1. In problem cases, upon the request of a physician, when the serologic evidence of the VDRL and RPCF tests is inconclusive and after repeat tests have been made.
2. As an aid to the Venereal Disease Control Officer of the Michigan Department of Health, upon all serologic specimens submitted with a request for the TPI test. It is anticipated that this will obviate the necessity for the TPI test in most instances.

Since the FTA test is a more costly and time consuming operation than the VDRL or RPCF, it is emphasized that this is **not** a routine test.

Effective February 22, 1965, the standard techniques to be employed in the examination of specimens submitted for rabies diagnosis are the fluorescent antibody method and animal inoculation. Details and exceptions to this directive are as follows:

1. Specimens received Friday p.m. and Saturday shall be examined by the direct slide method for immediate reporting. With the exception of rodents, specimens received Friday p.m. and Saturday shall also be examined by FA method and animal inoculation, the FA to be completed on Monday.
2. Rodent specimens received Friday p.m. and Saturday shall be examined by direct slide followed by FA, just as at present. Rodent specimens received throughout the remainder of the week shall be examined by FA method only. The FA examination shall be completed and reported the day after receipt of a specimen, under normal conditions.
3. Specimens other than rodents which are received Monday through Friday a.m. shall be examined by FA method and animal inoculation.

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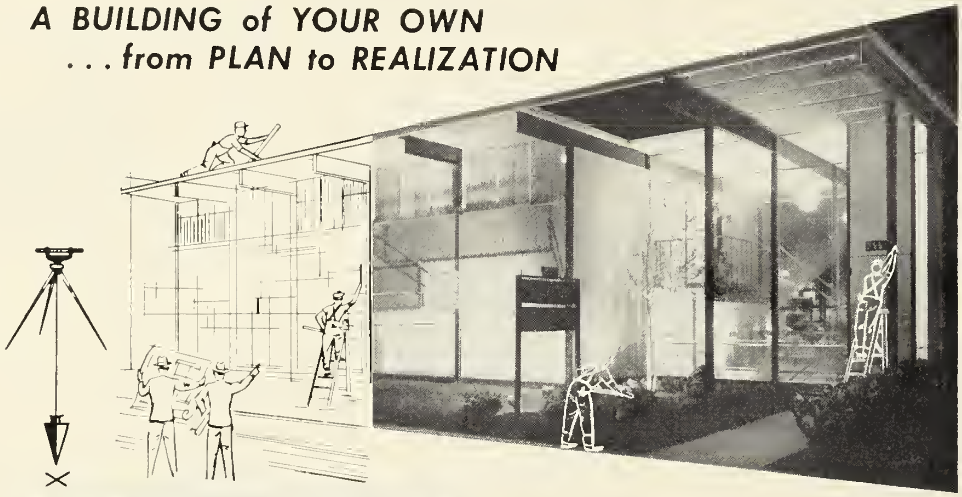

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# SOCIO-ECONOMIC

## Interesting Statistics About Education and Careers in Michigan

These three sets of figures appeared in a recent issue of the Michigan School Board Association Journal . . . and will be of interest to physicians.

A survey of the United States conducted by Kenneth G. Nelson, chief of higher education surveys section of the U. S. Office of Education, indicates that in 1962-63, 1,970,198 students completed their 12th grade of formal education. Of that number 1,007,838 entered college in the fall of 1963. This is a national average of 51% of all high school graduates in the United States entering college. The survey further shows that Michigan is below that national average. In the fall of 1963 only 40,024 of a total of 90,243 high school graduates entered college. This is only 44%, and ranks Michigan 39th among the 50 states and the District of Columbia.

*The Occupational Outlook Quarterly,* Bureau of Labor Statistics, U. S. Department of Labor, December 1963 indicates the following:

| Years of School Completed | Lifetime Earnings Ages 18-64 |
|---|---|
| Less than 8 years | $143,000 |
| 8 years | 184,000 |
| 1-3 years high school | 212,000 |
| 4 years high school | 247,000 |
| 1-3 years college | 273,000 |
| 4 or more years college | 417,000 |

* * *

**OCCUPATIONAL TRENDS AND EDUCATIONAL REQUIREMENTS**
**U.S. LABOR FORCE—1930 AND 1970**
**LABOR FORCE**

| | Unskilled | Semi-skilled | Skilled | Clerical & Sales | Semi-Professional* | Managerial | Professional |
|---|---|---|---|---|---|---|---|
| 1930 | 32% | 25% | 10% | 15% | 4% | 8% | 6% |
| 1970 | 5% | 21% | 12% | 20% | 20% | 10% | 12% |

*Note: This semi-professional percentage includes technical labor force

## Make National Study Of Blue Cross

(From Blue Cross News)

A survey is being conducted on the steps that the nation's 77 Blue Cross plans are taking to promote prudent use of hospitals.

The Blue Cross Association made the survey to gain a measure of the plans' systematic efforts to hold down hospital costs.

The Blue Cross plans pay a total of two and one-half billion dollars in hospital bills for their members each year.

Walter J. McNerney, BCA president, said that the plans have a responsibility to see that the funds are being spent effectively.

"Most of us in Blue Cross are becoming convinced," he said, "that one of our greatest challenges is to create and support active programs which will discipline the amount, appropriateness and effectiveness of care being rendered to the American people through the voluntary health system.

"As we all know, the attentions of the general public, of the purchasers of medical care, and of the government (both as a regulator and as a major purchaser) have become focused on how well funds are being expended for the care rendered to people," McNerney said.

"It has become evident to most Blue Cross officials and most hospital and medical leaders that mechanisms must be developed which will assure and reassure the public that money for medical care is being spent effectively."

The demand for controls is growing in response to rising hospital costs. According to the American Hospital Association, average costs to the hospital per patient per day have risen from $9.39 in 1946 to $38.91 in 1963, an increase of 314 per cent.

"The major industrial employers and unions are demanding more evidence of controls," McNerney said. "The government . . . is beginning to look toward Blue Cross as a system which can combine public responsibility, professional skills and rapport with all segments of the medical economy for this purpose."

## More and More Covered By Health Insurance

Individual and family insurance policies issued by health insurance companies protect nearly 15 million more people today than they did ten years ago.

The Health Insurance Institute reports that in 1953, companies provided individual programs to 23,475,000 Americans; in 1963, the number protected that year totaled 38,065,000, an all-time high.

A total of 821 insurance companies issued individual policies in 1963, an increase of 26 per cent over the number of companies providing this protection in 1958, a 68 per cent growth over the 490 companies issuing individual policies in 1953.

Planning Your Career

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NURSING
PHARMACY
NUTRITION
DENTISTRY
PUBLIC HEALTH
SOCIAL WORK
ALLIED FIELDS

CONSIDER THE OPPORTUNITIES AS A

Medical Associate

# *Many Praise MSMS Career Booklet*

Letters of praise arrive from Michigan and across the nation every week at MSMS for its booklet "Planning Your Career—Consider the Opportunities as a Medical Associate."

The booklet is one of very few about careers as medical associates, twenty-one careers are included. The information is slanted toward Michigan education training programs but is effective for school counselors, science teachers, future nurse clubs, etc., across the Nation.

Many county medical societies in Michigan have used the booklet effectively at its Medical Career days. Several AMA booklets about careers in medicine can be used to compliment the MSMS publication.

* * *

THE COMPLIMENTARY letters from schools, students and parents are only outnumbered by letters of request. The MSMS office recently tabulated the requests during a short period and reported 148 requests from Michigan, 40 from New York, 36 from Pennsylvania, 34 from Missouri, 21 from Illinois, and many from 31 other states. There were two from Canada.

Word that such a publication exists seems to spread rapidly among the school counselors and the state departments of public instruction.

The MSMS booklet was first printed in 1948, and has been reprinted and revised several times since. The cover contains the following copy which is testimony to its value:

**First Printing, 1948, 17,000 copies**
**Second Printing, 1952, 10,000 copies**
**Third Printing, 1954, 10,000 copies**
**Fourth Printing, 1959, 10,000 copies**

Following are some typical comments received by MSMS about this public-service, public-relations publication:

D. W. Beardslee, Iron Mountain Counselor wrote, "The booklet is very helpful and informative."

M. F. Leah Beardslee, N.O.P. personnel supervisor, University Hospital, Ann Arbor, wrote, "The booklet is attractive and well done. The fold-out information chart was comprehensive, worthwhile; a most interesting and important feature."

* * *

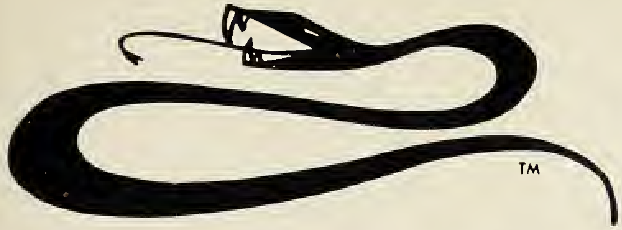
EDWARD JACKSON, Counselor, Reinbeck, Iowa, commented, "The photographs help give a word picture of the vocation. I feel the fold-out information chart in the back of the booklet is an excellent addition to the booklet."

Larry L. Williams, Director of Guidance, Aledo High School, Aledo, Illinois, declared, "Over all, I think the brochure is very comprehensive and informative. To the best of my knowledge, the most significant areas in medicine have been included and well covered."

Melvin J. Veldhuizen, Counselor, Loveland High School, Loveland, Colorado, wrote, "I am impressed with the overall publication. The photographs give an excellent impression of the work in each vocation. While the individual description of each vocation is very general, it is my feeling that this booklet is to serve as an overall survey of the occupations involved in the medical associate field. The information chart in the back of the booklet is excellent and certainly aids the curious student in gaining a good overview of a particular vocation. I am very pleased with the publication."

Ernest Schroeder, Guidance Director, Oconto,

## PUBLIC RELATIONS



**WARNING**

**KEEP OUT OF THE REACH OF CHILDREN**

## Doctors Join Drive For Poison Prevention

Many doctors of medicine are cooperating with the Michigan State Pharmaceutical Association in its continuing Poison Prevention Campaign.

MSPA President Royce N. Kephart, R.Ph., of Traverse City, reports that the MSPA distributed more than half a million "warning" labels last year and received many inquiries about its newly-designed coiled snake emblem. The Michigan effort this year was expanded to a national scale by the American Pharmaceutical Association, which is now using the special poison prevention materials created by the Michigan Pharmaceutical Association.

Sheets of the gummed poison prevention labels are available from MSPA, 1812 Michigan National Tower, Lansing.

---

### Continued: Career Booklet

Wisconsin, reported, "I liked this publication very much. A great deal of the material that I send for to be used in my files, I do not get an opportunity to read. However, this one did catch my eye. I read through it and I especially was impressed with the chart at the back. This is excellent. I am very happy and pleased with this booklet."

* * *

ROSS H. BRUSH, Director of Guidance, Tularosa, New Mexico, declared, "The fold-out chart in the back is an excellent device. I have seen students spend considerable time studying this chart after thumbing swiftly through the pages. This is one of the best pieces of occupational information that we have received."

John E. Falt, Guidance Officer at the Almonte High School, Almonte, Ontario, wrote, "Even though Canadian students use the booklet I feel it is valuable for them. We do have the occasional American citizen who needs the information as well."

Evelyn L. Naylor, Director of Guidance, Statington, Pennsylvania, commented, "We appreciate the privilege of having this material in our files. It has met our needs completely."

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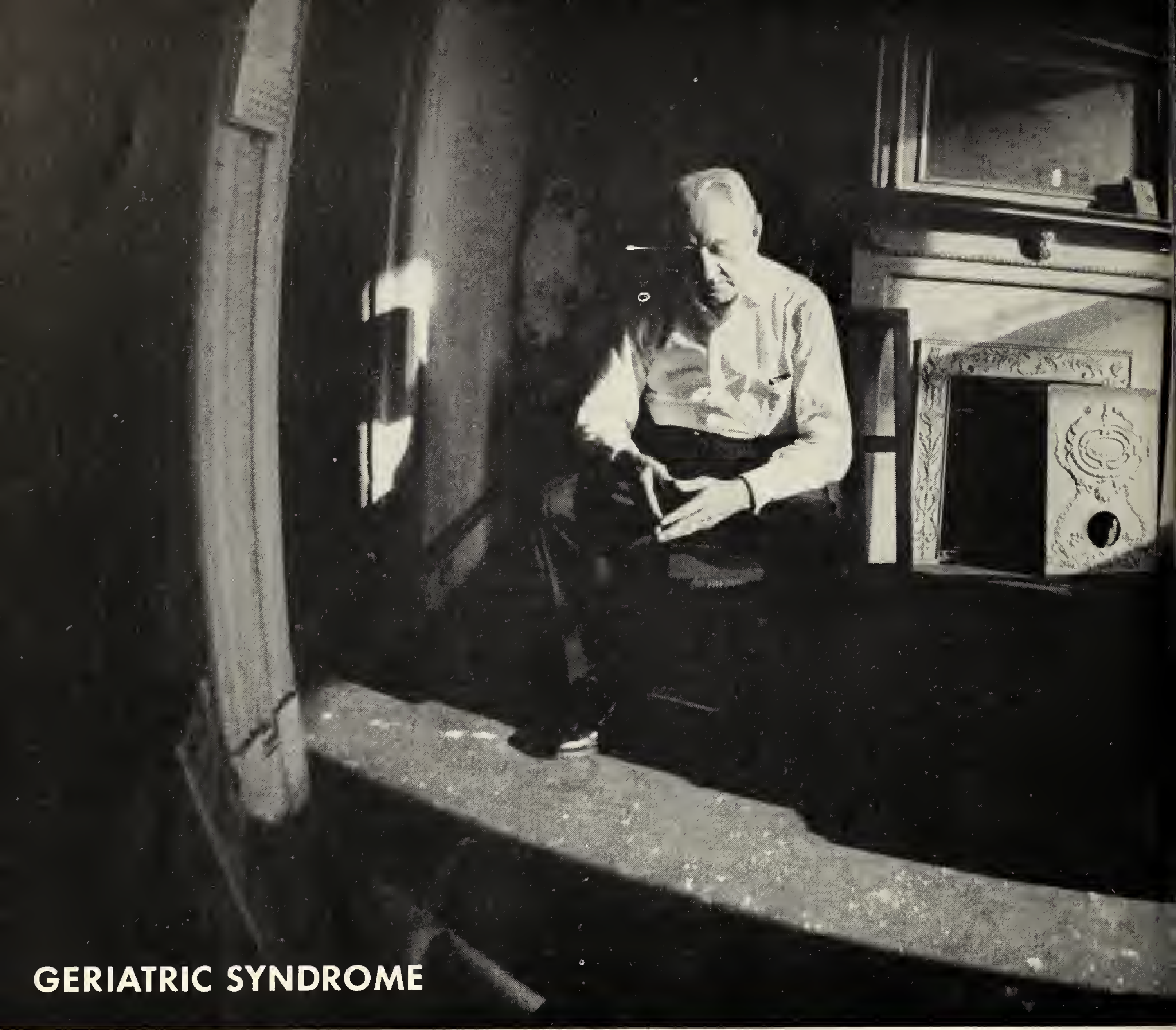

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**Side effects and precautions:** The transitory drowsiness which may occur with hydroxyzine HCl usually disappears spontaneously in a few days with continued therapy, or is correctable by dosage reduction. Dryness of the mouth may be seen with higher doses. Involuntary motor activity has been reported in hospitalized patients on higher than recommended doses. Hydroxyzine HCl may potentiate CNS depressants, narcotics such as meperidine, barbiturates, and anticoagulants. In conjunctive use, dosage for these drugs should be decreased. Because drowsiness may occur, patients should be cautioned against driving a car or operating dangerous machinery. **Parenteral Solution Precautions and contraindications:** This dosage form is intended only for I.M. or I.V. administration and should not, under any circumstances, be injected subcutaneously or intra-arterially. When the usual precautions for I.M. injection have been followed, reports of soft tissue reactions have been rare. I.V. administration should be slow, no faster than 25 mg. per minute, and should not exceed 100 mg. in any single dose. Particular care should be used to insure injection only into intact veins; a few instances of digital gangrene occurring distal to the injection site have been attributed to inadvertent intraarterial injection or periarterial extravasation, both of which should be avoided. **More detailed professional information available on request.**

# Urge Immunization Against Measles

An intensive MSMS educational effort for immunization against measles is still underway having started on March 1. MSMS and the county societies seek to inform parents of the dangers of measles and to encourage them to consult their physician regarding vaccination for measles.

In this public-service campaign, MSMS is using every means of communication—the daily and weekly press, radio and TV spots and programs, billboards, car cards and professional journals. Through these media, MSMS is calling attention to the facts that:

1. Far from being a harmless disease, measles is a crippler and a killer.
2. Practically every child is susceptible to measles by the time he is nine months old.
3. One child in six who get measles will develop a secondary infection.
4. In one case in 1,000, measles trigger dreaded encephalitis which in some cases even kills.

This MSMS Measles Campaign is being conducted with the cooperation of Merck Sharp & Dohme, who is furnishing promotional materials and other assistance free of commercial overtones and without use of its name.

Newspaper headlines on news releases from the MSMS Headquarters are helping to reach the parents. These headlines include:

*Sault Ste. Marie Evening News:*
Eradication of Measles
Target of Medical Group

*Flint Journal:*
Measles Immunization
For Children Is Urged

*Port Huron Times-Herald:*
Advises Use
Of Measles
Vaccine

*Cadillac Evening News:*
Vaccine Usage
Could Eliminate
Measles Problem

*Holland Evening Sentinel:*
Measles Can
Be Wiped Out

*Detroit News:*
Miserable Measles
—No Place to Hide

*Detroit Free Press:*
Vaccinations Urged
To Avert Outbreak

*Lansing State Journal:*
Measles Immunity
Campaign Launched

*Frankenmuth News:*
War Against Measles Goes on as Medics
Promote Campaign for Immunization

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ideally suited for routine TB screening

**accurate**—comparable to the older standard intradermal tests
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Side effects are possible but very rare: vesiculation, ulceration or necrosis at test site. Contraindications, none; but use with caution in active tuberculosis. *Available* as the new individually-capped unit, boxes of 5, or in cartons of 25.

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## Wayne M.D.'s, Clergy Offer

Several hundred physicians and clergymen attended the 1965 Joint Wayne County Medical Society Meeting of Physicians and Clergymen, March 1. Shown here before the dinner are, left to right, Ralph Cooper, M.D., MSMS Councilor, Detroit; Rev. Dr. Paul B. McCleave, Director of the AMA Department of Medicine and Religion; W. C. C. Cole, Sr., M.D., WCMS President, and John Moses, M.D., Moderator for the Detroit program. Edward Tallant, M.D., and Laurence Segar, M.D., also spoke on the panel. Prior to the dinner meeting, the MSMS Committee on Medicine and Religion met at the WCMS Building and all attended the Wayne program.

(Michigan Medicine Photo)

Photo above shows a portion of the WCMS and MSMS members who attended the annual WCMS meeting for Physicians and Clergymen, held at the WCMS headquarters. (Michigan Medicine Photos)

### Northern Hears Stroke Speaker

The Northern Michigan Medical Society met at Petoskey to hear an address by John Gilroy, M.D., Detroit, about research into the causes and cures for stroke.

### Washtenaw Joins Pharmacists

Members of the Washtenaw County Medical Society were guests of the Washtenaw County Pharmaceutical Society recently to hear Robert Haakensen, community relations manager of KSF Laboratories for an address about "Mr. Health Team Member, Speak Up."

### Newaygo Aids Handicapped

Proceeds from the polio clinics have been given by the Newaygo County Medical Society to the Neway School for handicapped children. A check was given to the school for $2,800.

# COUNTY SOCIETIES

### Bay Advises on Course

The Bay County Medical Society has provided advice to Central High School which next fall will offer a year-long course to help train medical office workers.

### St. Joseph Helps Hospitals

The St. Joseph County Medical Society has given $5,000 each to the Three Rivers Hospital and the Sturgis Memorial Hospital from proceeds of the polio campaign income. The Society has recommended that the money be used primarily for capital improvements.

## For the Asking:

The Pharmaceutical Manufacturers Association has produced a catalog of "Health Publications from the Pharmaceutical Industry," available from the Public Information Office, PMA, 1155 Fifteenth Street, N.W., Washington, D. C. 20005. More than 130 publications are listed with brief descriptions of their contents, and the audience for which they are intended.

In response to requests from physicians for information about medical meetings abroad, Group Travel Services, Inc., Kansas City, has published a directory of "Medical Meetings International." Copies of the brochure are available from Medical Meetings International, Broadway at 34th Street, Kansas City, Missouri, 64111.

A 19-minute optical sound color movie, entitled "Child Upper Extremity Amputees," made by Leonard F. Bender, M.D., professor of physical medicine and rehabilitation, is offered for sale or loan at the U-M Audio-Visual Education Center. The film follows 11 different amputees over as long a period as eight years of growth and development.

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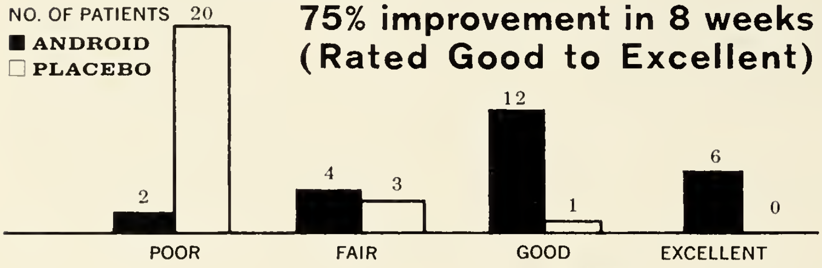

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| Thyroid Ext. (¼ gr.) | 15 mg. |
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| Glutamic Acid | 100 mg. |
| Pyridoxine HCl | 5 mg. |
| Niacinamide | 75 mg. |
| Calcium Pantothenate | 10 mg. |
| Vitamin B-12 | 2.5 mcg. |
| Riboflavin | 5 mg. |

Average Dose: One tablet twice daily
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* 1. *Treatment of Impotence with a Methyltestosterone-Thyroid Compound (Android),* M. H. Dubin, *Western Medicine,* 5:67 Feb. 1964.
2. *Methyltestosterone-Thyroid in Treating Impotence,* A. S. Titeff, *General Practice,* Vol. 25, No. 2, February, 1962, pp. 6-8.
3. *Thyroid-Androgen Relations,* L. Hellman, et al., *The Jrl. of Clin. Endocrinology and Metabolism,* August 1959.
4. Brochure Discussing Thyroid-Androgen Interrelationship.

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# MSMS, MNA Adopt Statement on Nursing Functions

The Michigan Nurses' Association and the Michigan State Medical Society have jointly established a liaison committee which, after much study, has developed both a "general statement" and a specific list of "dependent nursing functions" and "emerging independent nursing functions."

The general statement and lists of functions have been reviewed by the MNA Board and the MSMS Council and endorsed by both.

MSMS Legal Counsel, after exhaustive review of the list of functions, has rendered the following opinion to The Council: "I feel that the two so-called independent nursing functions mentioned . . . may properly and legally be recognized as such *as long, but only as long, as they are confined to special and emergency situations as life-saving measures and administered by those having adequate training.* Likewise, I believe that the seven listed independent nursing functions are not legally objectionable as such bearing in mind that they are predicated upon the assumption that *adequate training has been given and that the primary responsibility continues to be that of the doctor.*"

The statement, and the lists of functions, follow:

* * *

The Registered Nurse, through training and experience, should be considered an integral component of the total medical team in the care and welfare of patients. The functions and responsibilities fulfilled by a Registered Nurse are on a different level from the functions and responsibilities conferred by an M.D. degree, and these professional practitioners complement each other in their respective spheres of total patient care.

It is implied and understood that the Registered Nurse, in performing certain designated dependent nursing functions, will have received specialized training and instruction in these dependent functions, and that the execution of any new functions will be implemented only after these new skills have been acquired through training.

In general an M.D. will advise and direct an R.N. in these dependent nursing functions, yet certain special and emergency situations may arise where the trained R.N. must exercise these new skills and sound judgment, as a life-saving measure, without specific M.D. direction.

There are two major areas of nursing practice, one dependent on the physician's orders, and the other not requiring specific orders of a physician.

The following have become dependent nursing functions in many institutions whereas formerly they were definitely medical functions:

(1) *Administration of investigational drugs.* A nurse may administer a new or non-official or investigational drug on the direct written order of a physician, provided the physician assumes the full responsibility for action or interaction of the drug or drugs. A nurse may properly refuse to administer an investigational drug if there is a lack of definitive information as to its reaction or interaction and if adequate medical supervision is not immediately available.

(2) *Venapuncture and intravenous administration of a foreign substance.* A nurse, after definite instruction and on the direct order of a physician, will be permitted to do a venapuncture and intravenous injection.

(3) *Intratracheal suction.*
  A. A blind intubation will be permitted as a dependent function after training.
  B. Tracheal tube aspiration, after explicit direction and training, may be permitted.

Training, as defined by this Committee, combines theoretical information, plus actual supervised clinical practice, to the point where both the nursing and the medical staffs are in agreement on the proficiency of a trainee to perform a particular act.

(4) *General anesthesia.* A nurse not trained in the administration of general anesthesia should not be required to administer general anesthesia.

(5) *Vaginal examination.* After instruction and demonstration, a nurse will be permitted to do vaginal examinations only as part of a procedure for securing cervical smears and cultures.

(6) *Inhalation therapy.* Administration of inhalation therapy will be permitted to be given by registered nurses after due and proper training.

(7) *Levine Tubes (nasal-gastric).* Insertion of Levine Tubes in infants and children will be permitted *only* after additional training.

Certain dependent nursing functions are emerging as independent nursing functions in emergency situations. These include:

(1) *Closed chest cardiac massage.* The indications, limitations, technique, and complications of the procedure, as well as the underlying physiology, must be thoroughly understood. This requires special training and instruction.

(2) *Mouth-to-mouth resuscitation.* The exact technique and underlying physiology of the procedure must be thoroughly understood through instruction and demonstration. This dependent function is usually an emergency measure and sound judgment should dictate prompt action.

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# IN MEMORIAM

## Abel J. Baker, M.D.

Abel J. Baker, M.D., 89, Grand Rapids physician, died February 17 at Butterworth Hospital.

Born in Spring Lake, Doctor Baker was graduated from the University of Michigan School of Medicine in 1905. He practiced medicine in Grand Rapids for 57 years, retiring in 1961.

Doctor Baker was senior visiting physician at Butterworth and served as chief of staff from 1945 to 1949. He was a fellow of the American College of Physicians and the Sigma Xi honor society.

In 1957 Doctor Baker received the 50 Year Award of the Michigan State Medical Society, and was a Life Member.

## James Brotherhood, M.D.

James Brotherhood, M.D., 83, Grand Rapids pathologist and diagnostician, died February 5 at his residence.

Born in Brooklyn, N. Y., Doctor Brotherhood was graduated from Johns Hopkins Medical School in 1910. Following work in a health sanitarium at Clifton Springs, N. Y., he moved to Grand Rapids where he founded a bacteriological laboratory in 1915, the first in the city. He engineered the installation of the laboratory at Blodgett Memorial Hospital when the hospital was built. Doctor Brotherhood was a general practitioner and served as a pathologist at Grand Rapids hospitals. He retired in 1951, and then took charge of the laboratory work at the tuberculosis sanitarium in Muskegon until 1961 when he retired permanently. He was a member of the Pathological Society.

Doctor Brotherhood was a Life Member of the Michigan State Medical Society.

## Howell C. Crissman, M.D.

Howell C. Crissman, M.D., 68, Ferndale physician, died February 21 at his residence.

Doctor Crissman, a native of Washington, Michigan, received his medical degree from Wayne State University School of Medicine in 1922. He practiced medicine in the Detroit area for 40 years and was a board member of Ardmore Hospital, Ferndale.

He was a past treasurer of the Oakland County Medical Society.

## W. George Felcyn, M.D.

W. George Felcyn, M.D., 69, Detroit physician, died February 12, at his residence following a long illness.

A lifelong resident of Detroit, Doctor Felcyn received his medical degree from Wayne State University School of Medicine in 1927. He interned at Providence Hospital and was a staff member there until his death.

Doctor Felcyn was a Life Member of the Wayne State University Alumni Association.

## Benjamin T. Goodfellow, M.D.

Benjamin T. Goodfellow, M.D., 86, retired, died January 30, in Lapeer.

A native of Ontario, Doctor Goodfellow was a 1905 graduate of Wayne State University School of Medicine. Doctor Goodfellow practiced medicine in Flint and was on the staff of Hurley Hospital of that city for many years. Following his retirement in 1956, after 50 years of practice, he moved to Lapeer.

Doctor Goodfellow received the 50-year Award of the Michigan State Medical Society and was a Life Member of MSMS.

## Arthur P. Grigg, M.D.

Arthur P. Grigg, M.D., 57, Saginaw physician, died February 13 at St. Luke's Hospital.

A native of Saginaw, Doctor Grigg was a son of the late Doctor Arthur Grigg. He received his premedical training at the University of Michigan and was graduated from the McGill University Medical School in Montreal.

Doctor Grigg practiced medicine in Saginaw since 1938, except for a three-year period during World War II when he served in the U. S. Navy Medical Corps with the rank of lieutenant commander. He participated in several overseas invasions.

## Abraham H. Jacoby, M.D.

Abraham H. Jacoby, M.D., 67, Bay City physician, died February 7 at Tucson, Arizona.

Doctor Jacoby was graduated from Loyola Medical School in 1924. His hospital affiliations included Bay City General and Mercy Hospital of Bay City. During World War II Doctor Jacoby served in the Army from 1942 to 1946.

Doctor Jacoby was a Past President of the Bay City Chapter of the American Academy of General Practice and the Bay-Arenac-Iosco County Medical Society.

## Abraham Kapetansky, M.D.

Abraham J. Kapetansky, M.D., 63, Detroit general practitioner, died December 16, 1964.

Doctor Kapetansky was born in Russia and came to Detroit in 1908 where he practiced medicine for 38 years. Doctor Kapetansky was graduated from the Wayne State University School of Medicine in 1926 and was a member of the American Academy of General Practice.

*(More on Page 298)*

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## Albert H. Miller, M.D.

Albert H. Miller, M.D., 85, Gladstone physician and former MSMS Councilor, died February 27.

Doctor Miller received degrees in pharmacy and medicine from the University of Michigan in 1904. A Councilor of the Michigan State Medical Society from 1939 to 1953, Doctor Miller also served as Past President and Secretary of the Delta Schoolcraft Medical Society. He was a past medical coordinator of the Michigan Crippled Children's Commission.

Doctor Miller was a Life Member of the Michigan State Medical Society.

## Robert J. McPherson, M.D.

Robert J. McPherson, M.D., 72, Detroit physician, died February 20.

Doctor McPherson was born in Ontario and was a graduate of the University of Toronto Medical School. Since 1925 he was on the staff of Highland Park General Hospital.

## Edward O. Sage, M.D.

Edward O. Sage, M.D., 89, former chief medical officer of the Veterans Administration in Michigan, died February 3, in Detroit.

Doctor Sage received his medical degree from Kentucky University at Louisville in 1900, and practiced there until coming to Detroit in 1916. He served with the Michigan Mutual Hospital until World War I when he became a captain in the Medical Corps. He was chief anesthetist at Walter Reed Hospital. Following the war, Doctor Sage became chief VA medical officer in Michigan and later was made chief medical officer for the Louisiana regional VA office. Doctor Sage was with the psychiatric division of Recorder's and Traffic courts in Detroit and in 1946 was named medical director of the Detroit and Cleveland Navigation Company.

A Life Member of the Michigan State Medical Society and the Wayne County Medical Society, Doctor Sage was a charter member of Phi Xi medical fraternity.

## Ralph W. Ridge, M.D.

Ralph W. Ridge, M.D., 79, an eye, ear, nose and throat specialist of Wyandotte, died February 7.

Doctor Ridge received his medical degree from the University of Michigan in 1909, and practiced in Coldwater. In 1921, he moved to Wyandotte where he practiced medicine for 44 years. Doctor Ridge's hospital affiliations included Wyandotte General Hospital, Oakwood at Dearborn, and Outer Drive at Lincoln Park.

In 1959, Doctor Ridge received the 50-Year Award of the Michigan State Medical Society. He was a Life Member of MSMS.

*(More on Page 299)*

## Raymond A. Tearnan, M.D.

Raymond A. Tearnan, M.D., 78, Munising physician, died February 22 in New Mexico.

A 1912 graduate of Harvard Medical School, Doctor Tearnan interned at Augustana Hospital in Chicago. He limited his practice to surgery from 1931 to 1951, when he became health director of Alger and Schoolcraft Counties, the position he held at the time of his death.

Doctor Tearnan was honored by the Michigan Health Officers Association in 1961 and was a Life Member of the Michigan State Medical Society.

## Edward H. Zwergel, M.D.

Edward H. Zwergel, M.D., 57, Kalamazoo physician, died January 9, 1965, at his residence.

Born in Niles, Doctor Zwergel practiced medicine in Cassopolis for 22 years. While a member of that community, Doctor Zwergel served as president of the Cass County Medical Society.

In 1958 Doctor Zwergel joined the faculty of Western Michigan University as director of student health services, the post he held at the time of his death.

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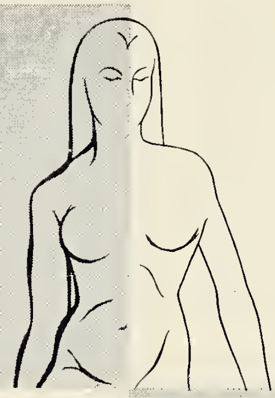

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*Rhoda Jones, Administrator*

## Readers Write:

Editor:

I have wished for several months to express my admiration for the many improvements in Michigan Medicine. I think these must have come as a result of my perspicacity, courage, and imagination. They have raised my expectations enormously as I open each issue.

I thought you might be interested in my feelings about the note Among the Great Printing Changes on page 96, February '65; they seem to be at variance with those of the majority. I have seen many examples and have found each to be bewildering, inadequate and as maddening as any blurred perception is. I suspect that this may be related to my life-long necessity of adjusting to monocular vision.

Of course, I expect the opinion of most to prevail.

John Maley, M.D.
Ann Arbor

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Copies of a new AMA-ERF "Handbook for Making Bequests to Medical Research" are available to interested physicians from the AMA-ERF, 535 N. Dearborn Street, Chicago, Illinois 60610. A copy of the handbook is on file in the MSMS Public Relations Library to assist physicians, attorneys and trust officers.

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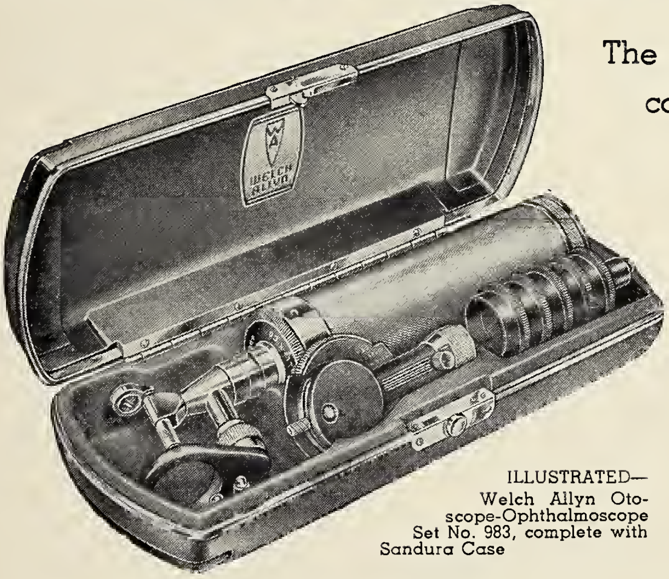

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# Reporting as Ordered

**A Monthly Commentary**
**By HUGH W. BRENNEMAN,**
**Executive Director**

The beautiful headquarters building at 120 West Saginaw has been described as a "quiet beehive." That definition is particularly apropos these days as the height of the season for organizational activity reaches its peak.

Trucks rumble into the loading dock to pick up and deliver exhibits, mountains of mail and millions of sheets of paper and other supplies. Committee members come and go at all hours of the day and night. The staff stretches just a little bit more to meet the ever-growing demands of the alert and vital organization they serve.

*A frequent visitor is William John (Jack) Brown of the American Medical Association. Jack is one of 12 field men who work under Aubrey D. Gates, Director of the AMA Field Service Division.*

Just as MSMS is striving to build closer relations with its county medical societies through the field service visits of Ralph Wills so the AMA is developing closer liaison with Mr. Brown.

You may be meeting Jack one of these days because he's not limited to visiting the MSMS headquarters and has already attended a number of county medical society meetings. Jack is responsible for Michigan, Minnesota and Wisconsin. His background is in the publishing field and although he was born in Cornwall, England, he was reared in Jeannette, Pennsylvania, and graduated from the University of Pittsburgh.

*All of us have watched the mileage recorder on our speedometer gayly click along tabulating our mileage as we drive. The MSMS has such a recorder except that it records the number of pieces of mail prepared for distribution from its headquarters. Last year was a record year, the total being 444,142. This is the first year that the ⅓ million mark was passed.*

Inasmuch as the "image" of an organization to its membership is set by virtue of its publications, more and more attention is being given to the caliber of the materials.

Most doctors take it for granted that their State Society is "looking after things" in the Michigan Legislature. Truly, it is observing constantly the bills introduced and the reception accorded them. Relatively few members know, however, that about 10% of the bills introduced into the Michigan Legislature directly affect the health professions and thus medicine. Most sessions are averaging 1500 bills per year (in 1964, 1486 bills plus resolutions were introduced).

*Consequently about 150 have to be very closely scrutinized by the MSMS Legal Affairs Committee and staff. Of this number at least 50 or 60 are of paramount importance and of that number at least ½ will have formal hearings before the responsible committee of the House or Senate.*

When one considers the complexity of legislation and the factors influencing it, plus the tortuous passage of legislation through a two-chambered body and thence to a governor for approval, it is not difficult to understand that the organizational machinery necessary to follow and influence these bills must be itself complex.

Riding herd on the whole process for MSMS is Otto K. Engelke, M.D., Chairman of the Legal Affairs Committee, and his ramrod, Morris A. (Mike) Riley. Meanwhile, back at the ranch, Mike's secretary, Delta Berry, melts the paperwork with her warm smile and flying fingers.

The Legal Affairs Committee is not above asking for help from any member who happens to be in a position to give such assistance. Keep that in mind when next your medical assistant says, "Doctor, somebody from the State Medical Society is on the line and wants to talk to you about a piece of legislation." You may be the key person to make possible a proper legislative decision. Your help is always, always, always greatly appreciated.

If you have read this far you are a friend indeed, so let me offer a tip: Make your reservation now for the days you will be attending the MSMS Centennial Session in Detroit. If you do so, you can specify the accommodations you want and can with reason expect to get them. There is going to be big crowd down there between September 19 and September 25. They are going to be having a big time and you will want to be a big part of it.

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MICHIGAN MEDICINE
the journal of the michigan state medical society
May 1965 • Vol. 64 • No. 5

## THEMES SELECTED FOR CENTENNIAL SESSION SEPTEMBER 19-24, 1965—DETROIT

Sept. 19—Medicine and Religion Day

Sept. 20—Medicine and Business, Industry and Communications Day

**Sept. 21—Medicine and Medical Organization Day**

Sept. 22—Medicine and Science Day

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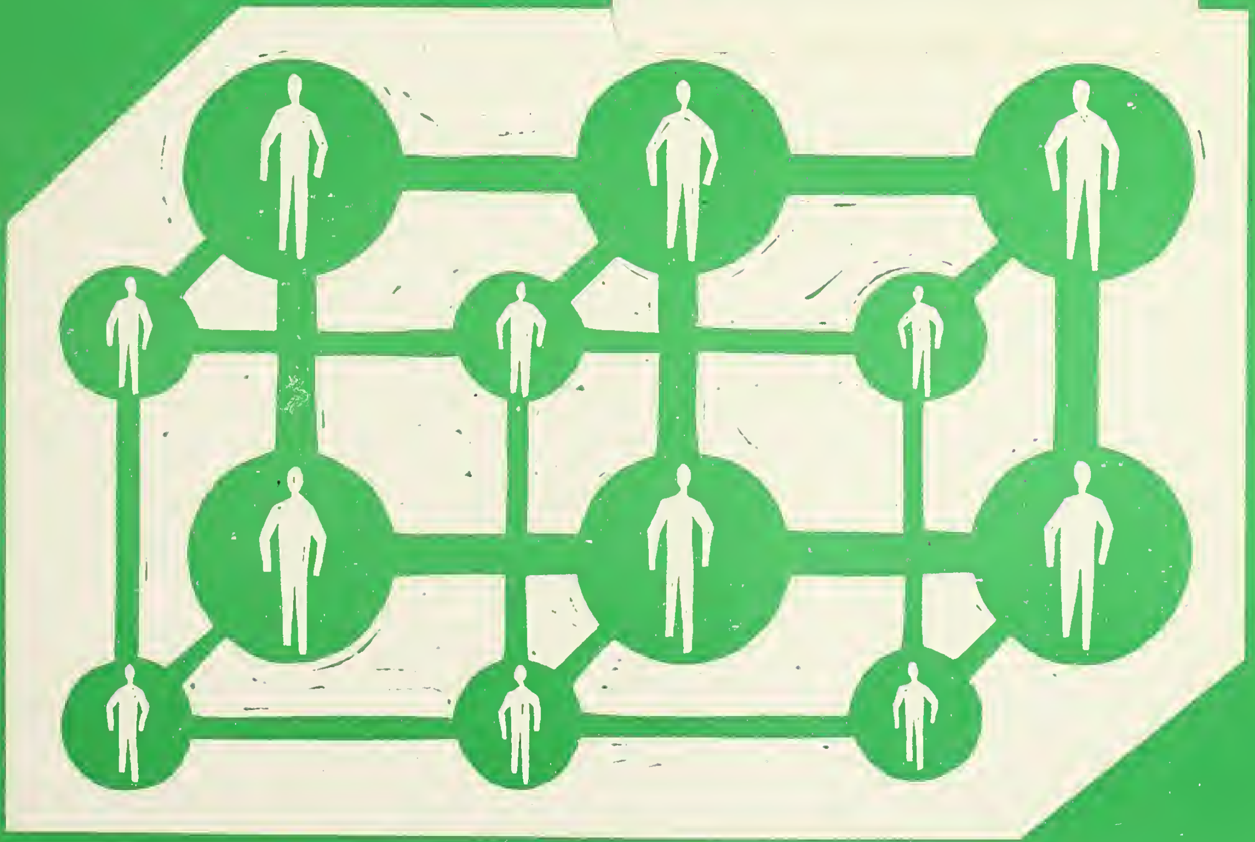

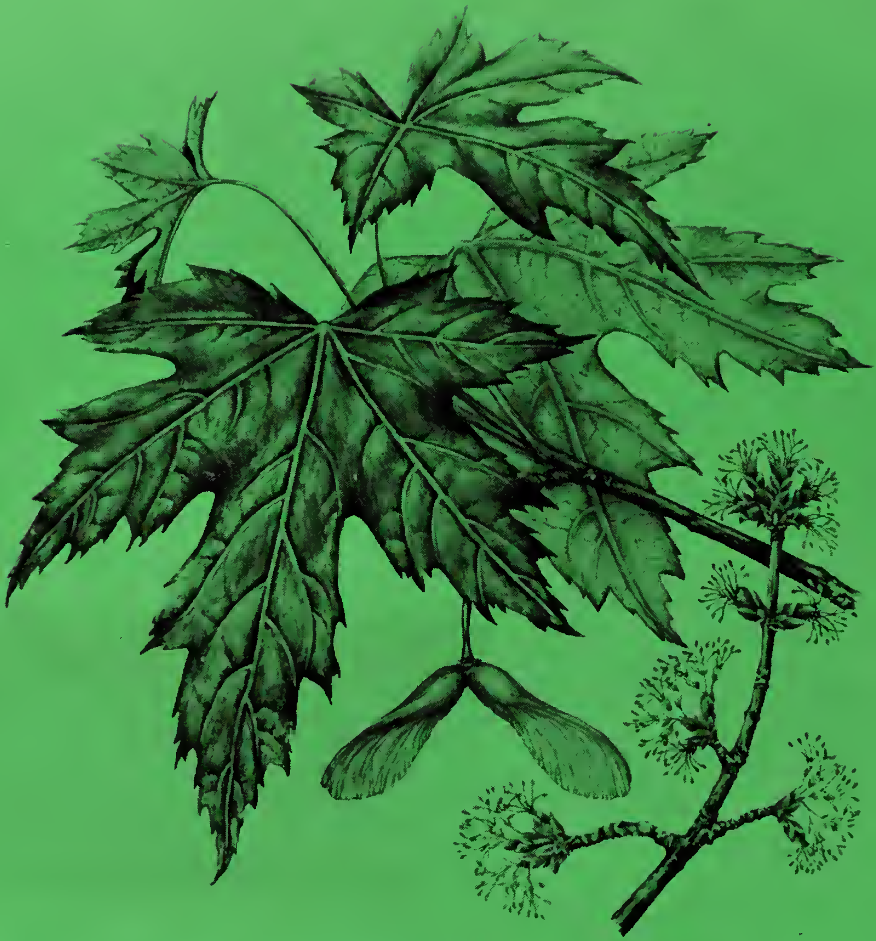

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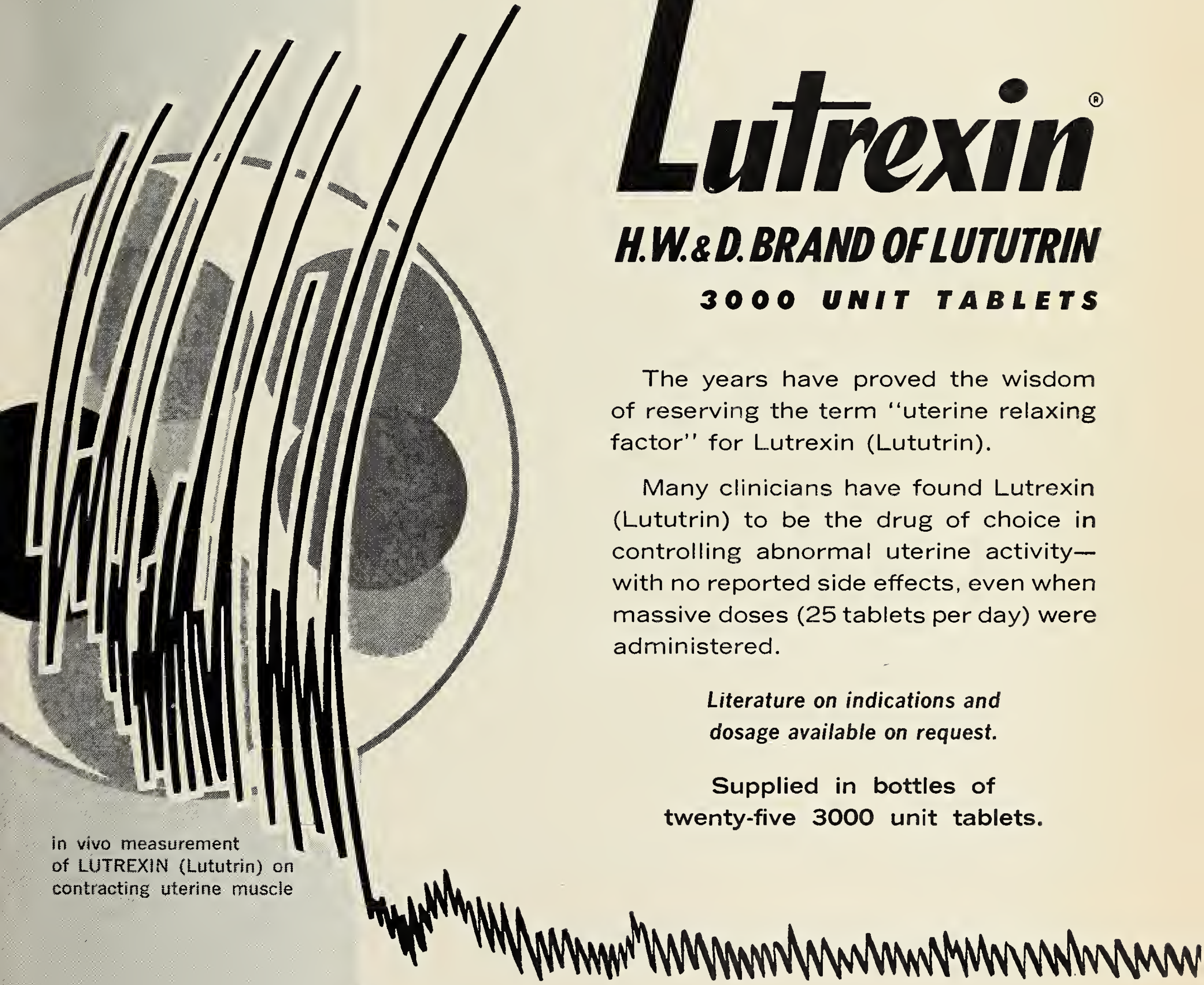

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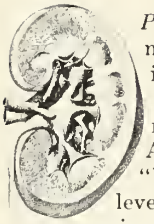

*Proteus mirabilis* is not only the most common cause of *Proteus* infections of the urinary tract, but such infections are often resistant to other antibiotics.[1-4] According to Anderson *et al.*,[5] "When assessed in terms of serum levels attainable with usual dosage regimens, ampicillin was the most effective drug tested against *E. coli* and *P. mirabilis*." These authors found *Klebsiella-Aerobacter* and *Pseudomonas* organisms relatively insusceptible to ampicillin. With its broad-spectrum coverage of many gram-positive and gram-negative bacteria, absence of toxicity, and slow emergence of resistant strains, PENBRITIN (ampicillin) is a most beneficial and safe drug in treating urinary tract infections—*killing* the pathogens, not just suppressing them.

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Published monthly except two extra issues to be published in October and December, by the Michigan State Medical Society as its official journal at 2642 University Avenue, Saint Paul, Minnesota 55114.

Second class postage paid at Saint Paul, Minnesota.

Yearly subscription rate, $9.00; single copies, 80 cents. Additional postage: Canada, $1.00 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year.

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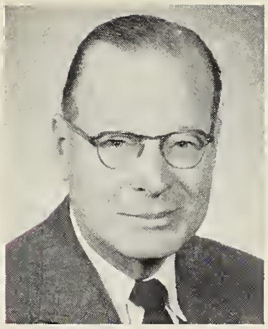


## *the president's message . . .*

## Spring and Legislation

Spring is a time of intense legislative activity on both the state and national level. Bills introduced in Washington have wide publicity in both press and TV, but bills that are proposed in the State House and Senate are rarely common knowledge until they reach the floor and have been passed.

As of now there have been about 1,250 bills placed in the hopper in the present Michigan Legislature. Of these about 5 per cent concern the health of the people of our state and are being studied by your Legislative Committee.

This Committee of 35 members is meeting frequently with our fine staff men who are assigned to this program. All bills that relate to health are carefully studied and a policy determined regarding each bill. These policies are then approved or disapproved by The Council which reviews the activities and suggestions of all committees.

Some of these bills, especially those we have suggested, can be approved as printed; others are supported after minor changes. A few are completely contrary to our philosophy and these must be vigorously opposed. With many new legislators in Lansing this year the opposition takes the form of a respectful presentation of our reasons for opposing the unacceptable bills.

Meetings are held early in the legislative year with the leaders of both houses and both parties. During the year doctors from various legislative districts are asked to come to the MSMS Headquarters and have dinner with their legislators. These conferences have been congenial and constructive.

Some bills that are proposed are the result of the recommendations of study commissions. The commissions are usually sincere, busy, exemplary citizens, but too often it is obvious that the final report is written by a welfare-state-minded member who is only too willing to thereby incorporate his socialistic theories. Because of the prestige of study commissions these bills have an insidious popularity in the Legislature.

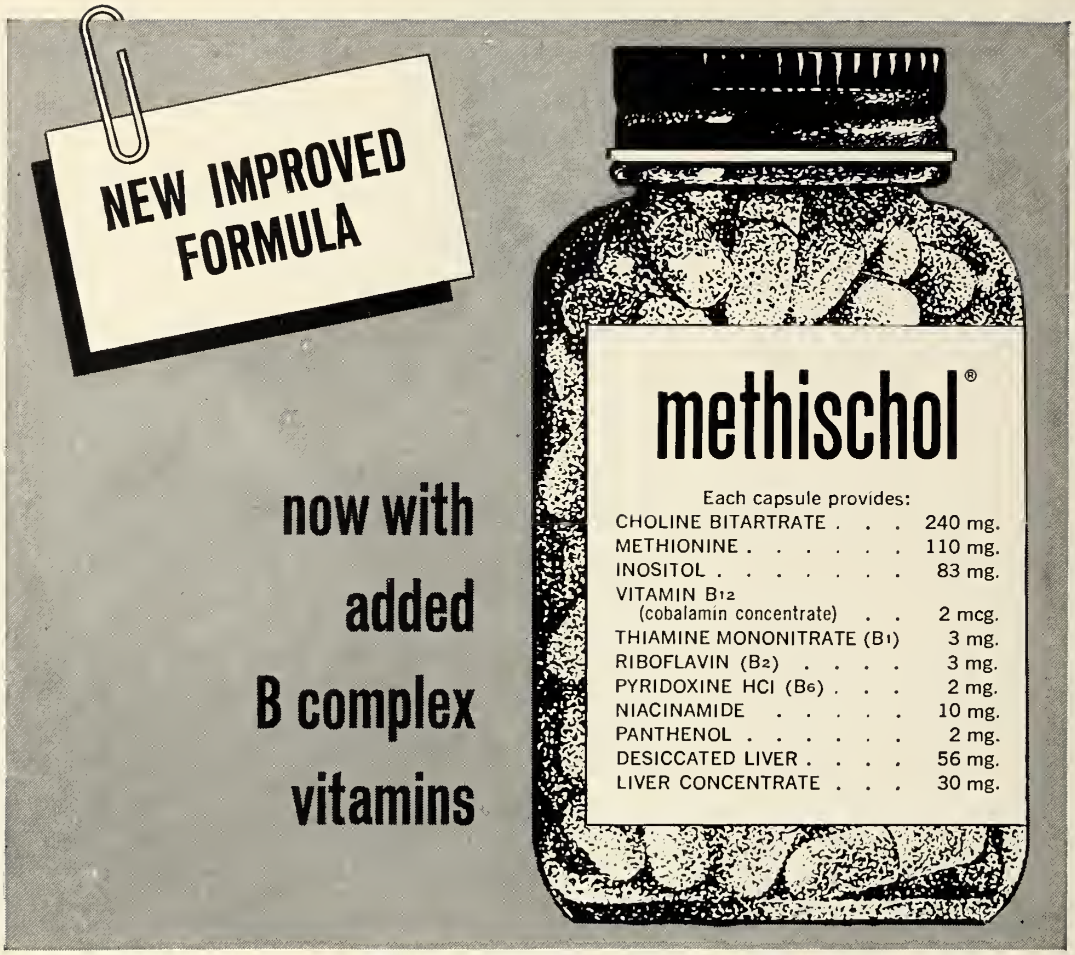
Many doctors are giving a great deal of their time working for good health legislation. You can do your part by expressing your opinions to your legislator.

Why not do it this week?

It is spring and bills today may become laws tomorrow.

*Oliver B. McGillicuddy, M.D.*

See Page 354 About Criticisms Facing Medicine.



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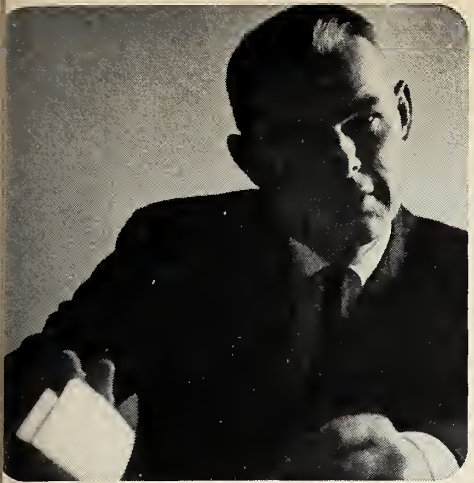
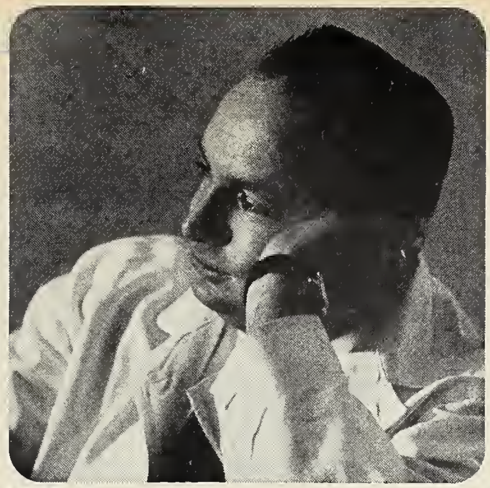


..and in previously treated hypertensive patients...



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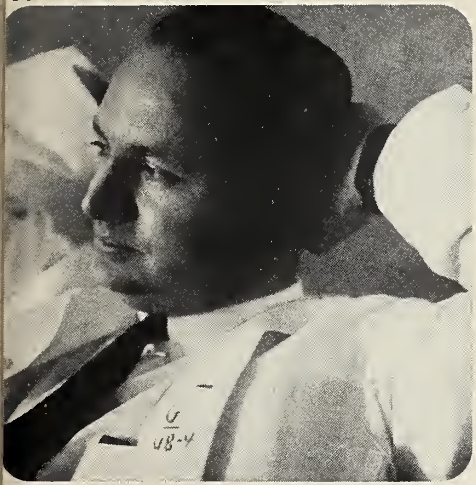

Uh-huh.

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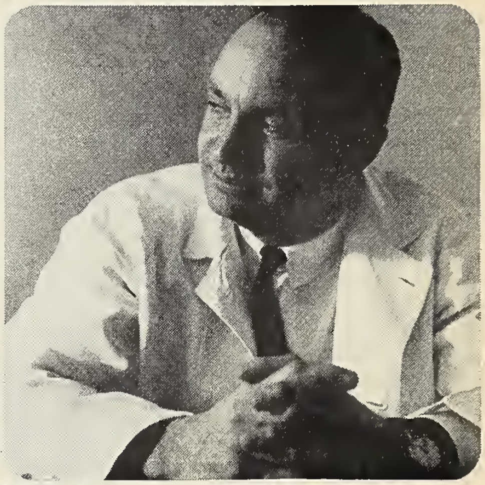

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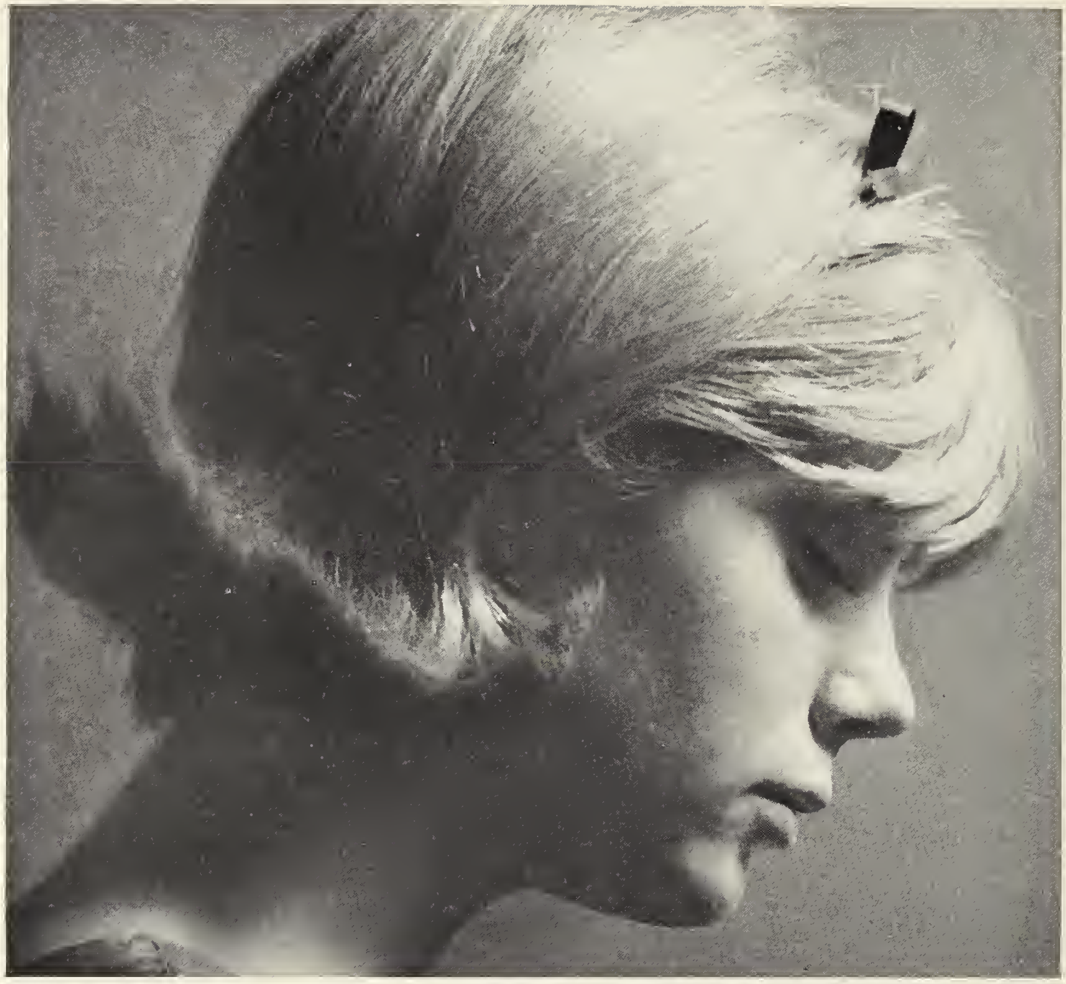

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**References: 1.** Handelman, Cathryn C.: Early management of acne, *Pediat. Clin. North America* 8:265, Feb., 1961. **2.** McLean, I. E. D.; Graham, K. T., and East, M. O.: The treatment of acne; a trial of "pHisoHex," *Practitioner* 189: 82, July, 1962. **3.** Hodges, F. T.: Therapeutic applications of an antiseptic detergent, *GP* 14:86, Nov., 1956. **4.** Wexler, Louis: Treatment of acne vulgaris, *Clin. Med.* 70:404, Feb., 1963.

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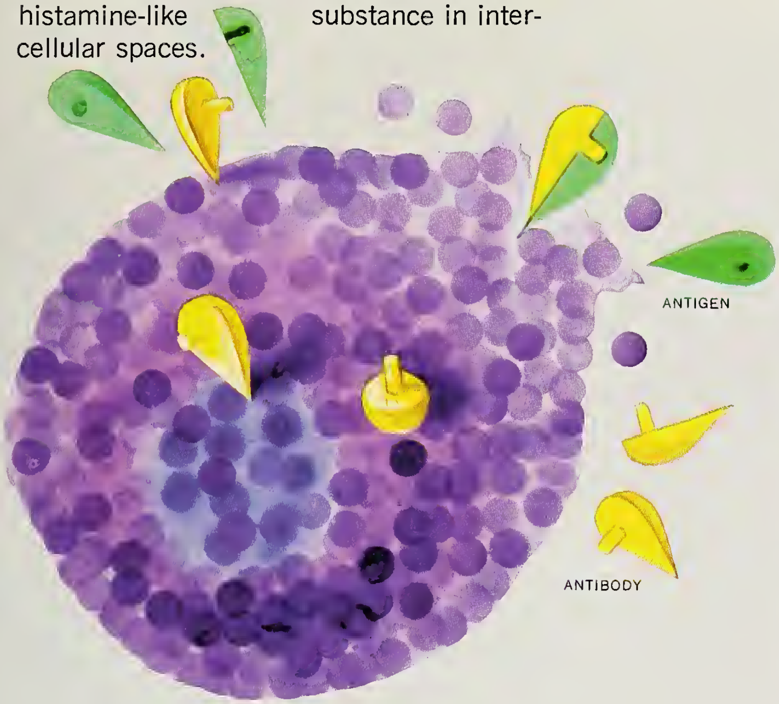

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*Schiller, I.W. and Lowell, F.C.: New England J. Med. *261*:478, 1959.

BRIEF SUMMARY: *Contraindications:* Hypersensitivity to antihistamines. Not recommended for use during pregnancy. *Precautions:* Until response is determined, patient should be cautioned against engaging in mechanical operations requiring alertness. *Side Effects:* Hypersensitivity reactions, including skin rashes, urticaria, hypotension, and thrombocytopenia have been reported rarely. Occasional transitory drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered. *Other dosage forms available:* conventional tablets (4 mg.); Elixir (2 mg./5 cc.); Injectable (10 mg./cc. ampuls, and 100 mg./cc. in 2 cc. vials).

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# basic therapy in low-back pain: bed, board, heat

Whether low-back pain is in the chronic or acute phase, the appropriateness of bed rest for such a patient is beyond controversy. Boards placed under the mattress, for a firmer bed to further immobilize the spine, are another common recommendation. And most investigators consider heat beneficial—moist heat in particular.[1-5]

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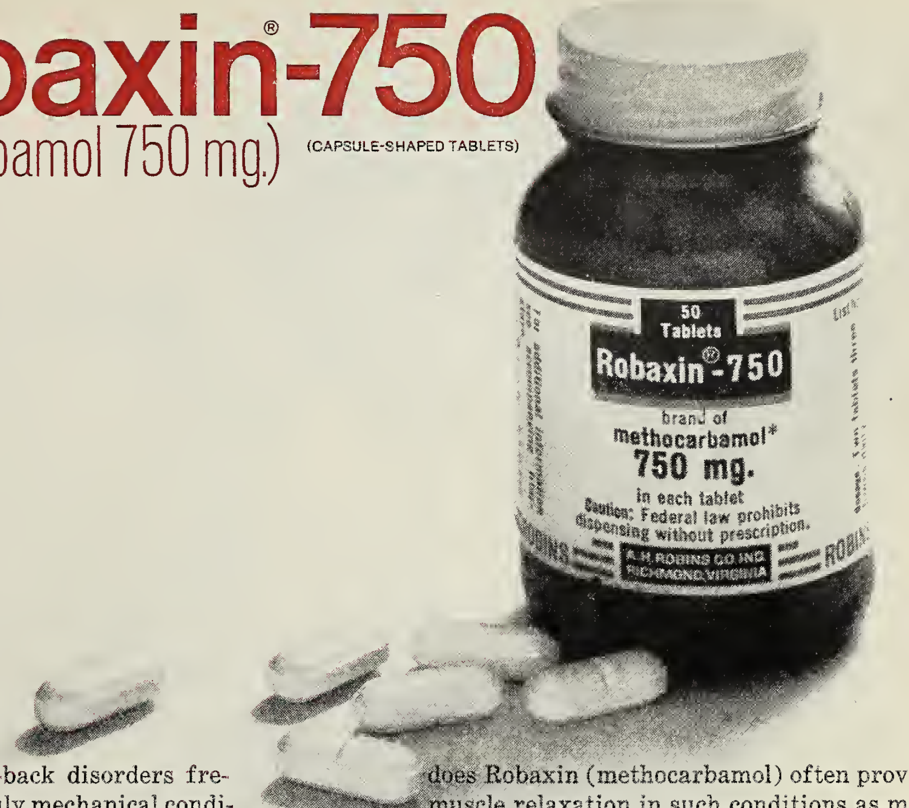

It has been noted that low-back disorders frequently "...are caused by truly mechanical conditions which yield to conservative treatment."[1] Basic to this conservative treatment are bed rest, a board for the bed, and applied heat. In addition, a good muscle relaxant is often helpful, as "...muscle relaxants are useful in chronic as well as acute low backaches."[4]

Robaxin (methocarbamol) has relieved spasm and pain in cases where the patient "had not responded to conservative measures prior to drug therapy."[6] A 100-patient study showed that Robaxin provided greater relief of muscle spasm for a longer period of time without adverse reactions "than any other commonly used relaxants...."[6]

A well-tolerated[7] skeletal muscle relaxant with "specificity of action,"[7] methocarbamol leaves normal muscle tone unaffected. Moreover, there is little likelihood of sedation[7]—a considerable advantage for the patient who must remain active and alert on his job.

Significantly, clinicians advise using a muscle relaxant "early and in adequate dosage."[8] In this regard, Robaxin (methocarbamol)—*particularly in the 750 mg. dosage (2 tabs. q.i.d.)*—offers optimal therapeutic benefits without a significantly increased incidence of side effects. And just as it works well as part of the basic regimen for low-back pain, so also does Robaxin (methocarbamol) often provide muscle relaxation in such conditions as musculoskeletal injury, chronic neurological disorders, and orthopedic situations.

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REFERENCES: 1. Soto-Hall, R.: Med. Sci. *14*:23, 1963. 2. McCarrol, H.R.: Paper read at the Annual Meeting of the American Medical Association, Atlantic City, June 16-20, 1963. See Medical News: J.A.M.A. *185*:39 (July 13), 1963. 3. Gordon, E.J.: Med. World News 5:54, 1964. 4. Cozen, L.: GP *26*:82, 1962. 5. Larson, C.B.: Postgrad. Med. *26*:142, 1959. 6. Forsyth, H.F.: J.A.M.A. *167*:163, 1958. 7. Weiss, M., and Weiss, S.: J. Amer. Osteopath. Ass. *62*:142, 1962. 8. Rowe, M.L.: J. Occup. Med. *2*:219, 1960.

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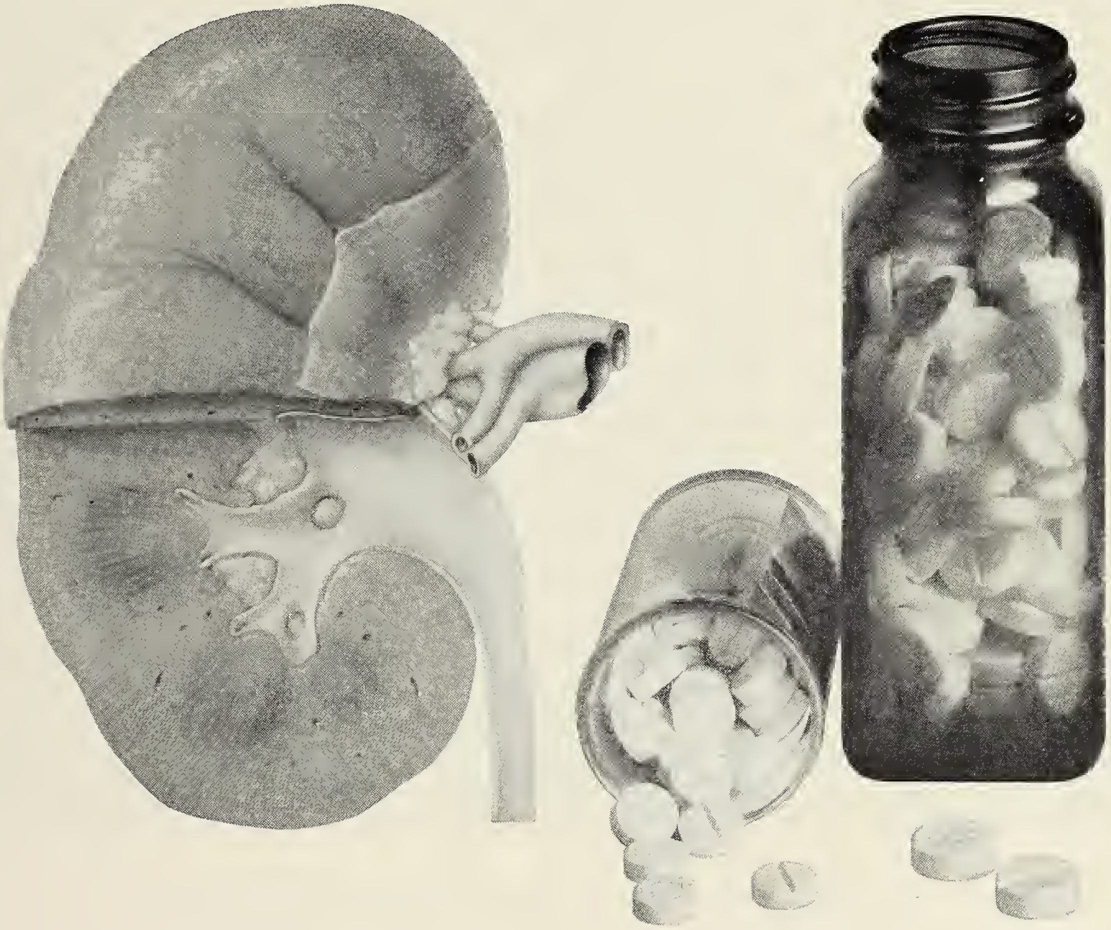

# understanding... precedes development

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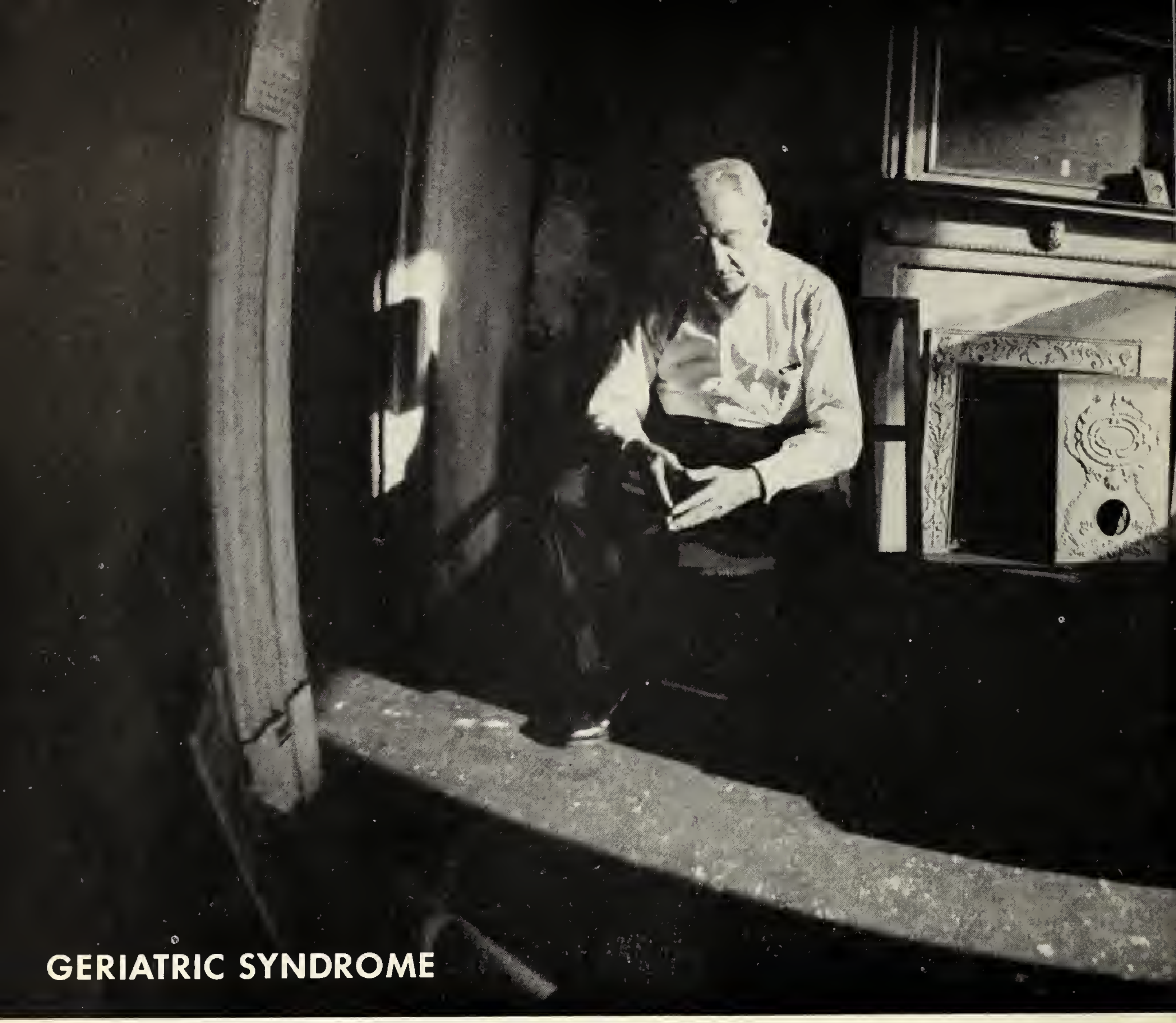

# when a change in environment overwhelms him with anxiety

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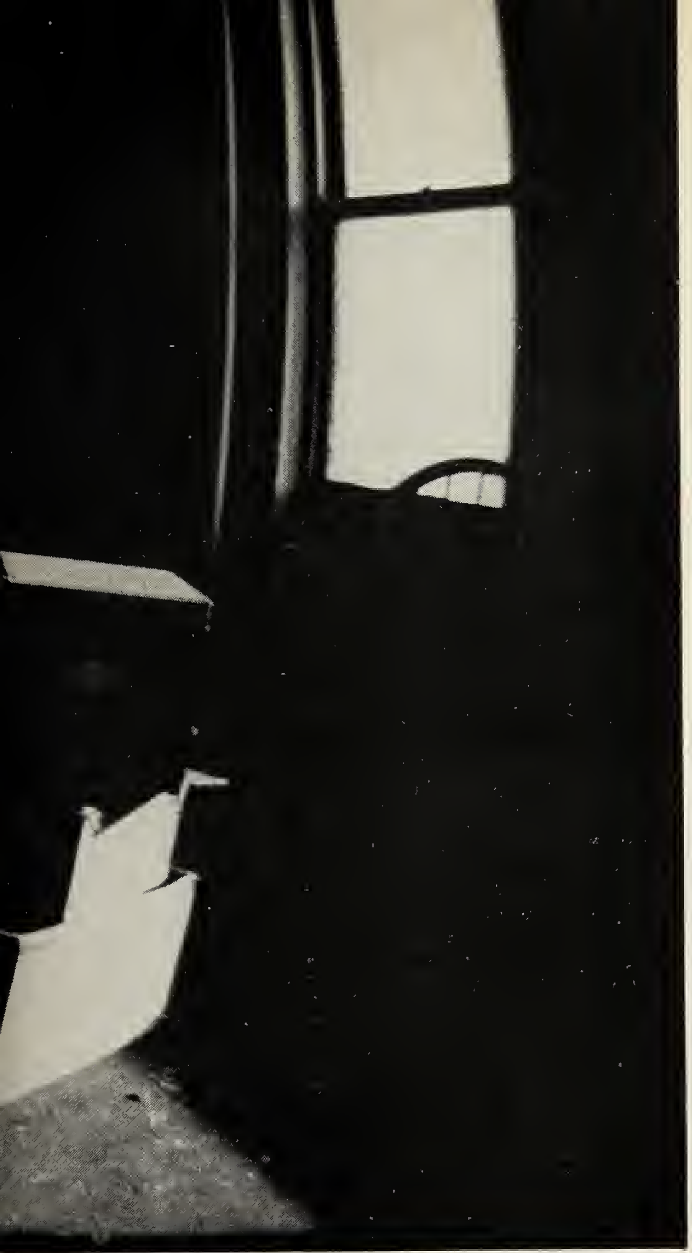

**Side effects and precautions:** The transitory drowsiness which may occur with hydroxyzine HCl usually disappears spontaneously in a few days with continued therapy, or is correctable by dosage reduction. Dryness of the mouth may be seen with higher doses. Involuntary motor activity has been reported in hospitalized patients on higher than recommended doses. Hydroxyzine HCl may potentiate CNS depressants, narcotics such as meperidine, barbiturates, and anticoagulants. In conjunctive use, dosage for these drugs should be decreased. Because drowsiness may occur, patients should be cautioned against driving a car or operating dangerous machinery. **Parenteral Solution Precautions and contraindications:** This dosage form is intended only for I.M. or I.V. administration and should not, under any circumstances, be injected subcutaneously or intra-arterially. When the usual precautions for I.M. injection have been followed, reports of soft tissue reactions have been rare. I.V. administration should be slow, no faster than 25 mg. per minute, and should not exceed 100 mg. in any single dose. Particular care should be used to insure injection only into intact veins; a few instances of digital gangrene occurring distal to the injection site have been attributed to inadvertent intraarterial injection or periarterial extravasation, both of which should be avoided. **More detailed professional information available on request.**

# NEWS BRIEFS

**Bruce Proctor, M.D.**, Pontiac, recently was reappointed to the Board of Governors of the American College of Surgeons.

One of the speakers at the Spring Conference for Operating Room Nurses held recently in Detroit was **Joseph Cerny, M.D.**, Ann Arbor.

**Ralph Green, M.D.**, and **Sheldon Siegel, M.D.**, both of Rochester, attended the annual meeting of the Central Neuropsychiatric Hospital Association in Chicago.

**Gerald Papenmeier**, who received his Ph.D. from Michigan State University, has been appointed research biochemist with the Ames Research Laboratory, Elkhart, Indiana. He formerly was a postdoctoral fellow at Brandeis University.

**Richard Aptekar**, formerly with a national supermarket chain and the headquarters of an international engineering society, is the new administrative assistant, Blue Shield Public Relations division.

**Les Harcus**, for the past three years director of home care for the Michigan Health Council, has been named public relations director of the Michigan Tuberculosis and Respiratory Disease Association.

The members of the Michigan Association of the Professions, at their annual 1965 Congress in Grand Rapids, re-elected **G. B. Saltonstall, M.D.**, Charlevoix, to the MAP Board of Directors.

A speaker at a Cleveland Clinic Educational Foundation course on "Recent Advances in the Diagnosis and Treatment of Thyroid Disease" was **J. Martin Miller, M.D.**, Detroit.

Several MSMS members spoke at the 13th Annual Clinical Meeting of the American College of Obstetricians and Gynecologists in San Francisco. They were **C. P. Hodgkinson, M.D.**, **C. L. Schneider, M.D.**, **J. P. Ottaway, M.D.**, **A. T. Salvaggio, M.D.**, **C. E. Darling, M.D.**, **R. R. Margulis, M.D.**, and **Warren Moore, M.D.**, all of Detroit; **J. H. Beaton, M.D.**, Grand Rapids; and **C. J. Behrman, M.D.**, and **Colin Campbell, M.D.**, both of Ann Arbor.

Measles vaccine was discussed by **Jean M. Holdredge, M.D.**, Detroit, on a recent MAP "Decisions" television program over WJBK-TV.

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**Ethel Calhoun, M.D.**, Birmingham, was one of the "Ten Top Women" selected during the "Salute to Women Who Work Week" in Detroit. Doctor Calhoun is director of the Sister Elizabeth Kenny Rehabilitation Center at the Pontiac General Hospital and executive vice president of the Sister Kenny Foundation.

The new Cyrus C. Sturgis Library of Hemotology was dedicated recently at the University of Michigan Medical Center. The Library, containing 1500 volumes on blood, is housed in the newly-furnished quarters at the Simpson Memorial Institute. **Chris J. D. Zarafonetis, M.D.**, is director of the Simpson Institute.

**Elmer W. Schnoor, M.D.**, a member of the Michigan State Board of Registration in Michigan for 26 years and a former president for 20 years, was cited at the 61st Annual Congress on Medical Education in Chicago. The Distinguished Service Award thanked Doctor Schnoor of Grand Rapids, "for his conscientious and unselfish interest in the welfare of the Federation of State Medical Boards." He is a past president of the Federation.

**Lula Belle Stewart Robinson, M.D.**, Detroit, recently was a recipient of the Carter G. Woodson Merit Award for achievements in educational, cultural, scientific and humanitarian pursuits.

**D. V. Sargent, M.D.**, Saginaw, member of the MSMS Committee on Medicine and Religion, participated in the Midland Lenten Family School for Christian Living faculty.

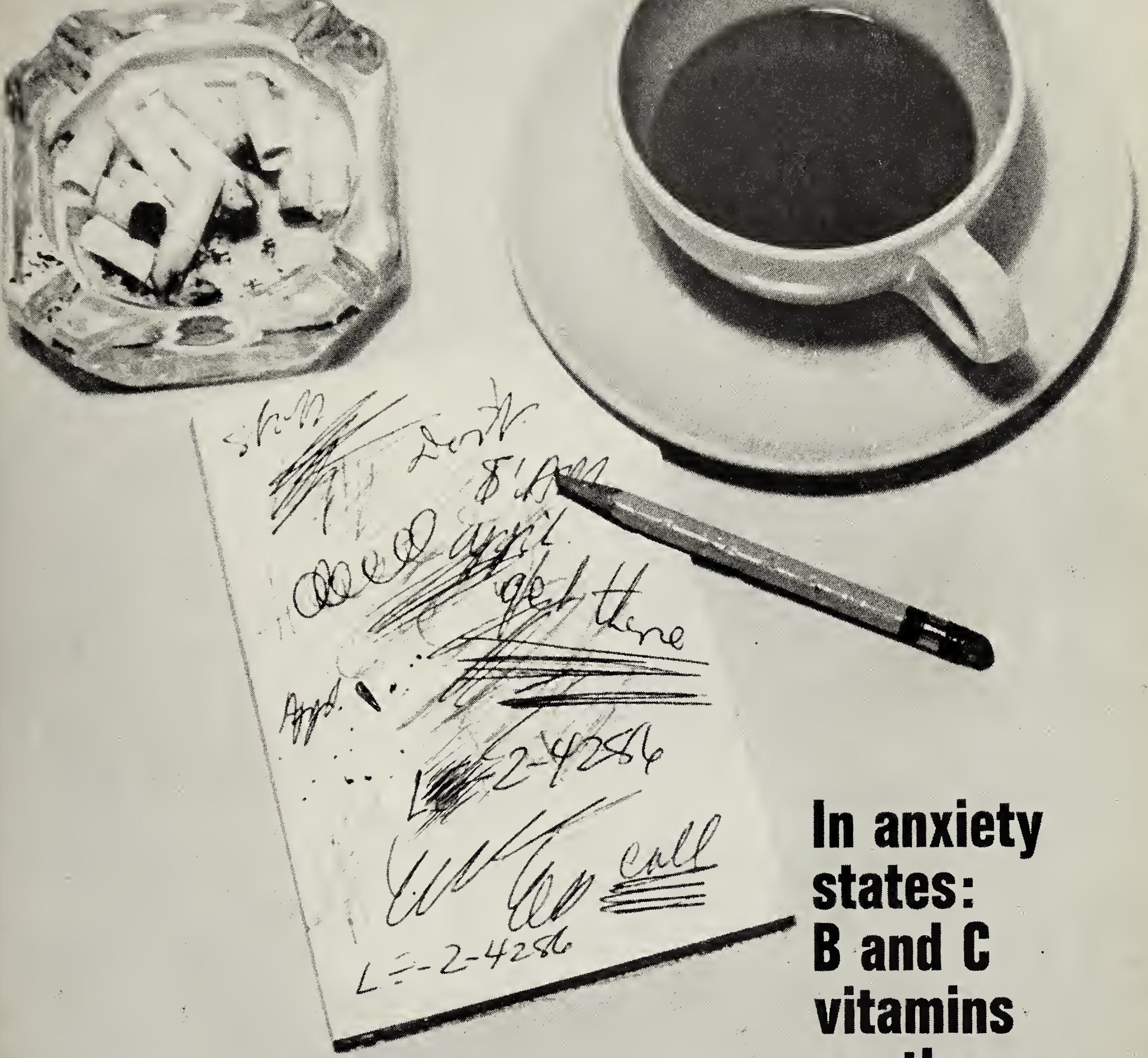
**John M. Dorsey, M.D.**, former chairman of the Wayne State University department of psychiatry and now university professor, received a Probus Club Award for Academic Achievement at the Club's annual dinner.

## Inhalation Therapists to Meet

Several MSMS members have been selected to speak at the Seventh Annual Inhalation Therapy Seminar, June 4-5, at the St. Lawrence Hospital, Lansing. The program is announced by the Michigan Society of Inhalation Therapists, a chapter of the American Association of Inhalation Therapists.

The program will include Thomas C. Blair, M.D., Lansing, on June 4 in a preliminary report on ultrasonic nebulizer therapy. On June 5, the seminar summary will be given by Jerome V. Mirkel, M.D., Lansing.

Registrations should be made in advance with Ben Goodard, Edward W. Sparrow Hospital, Lansing.



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# Common Sexual Problems In Marriage

By Peter A. Martin, M.D.
Detroit

It seems as if it has recently become open season on physicians to be accused of being woefully ignorant about sex.[1]

Accusations have been made that sexual education in medical schools is woefully inadequate. Criticisms state that very little is done to instruct students, or to deal with their fears about sex.

Physicians in practice claim that physiological and psychological considerations of coitus are largely avoided in any sort of direct instruction by the faculty of medical schools; that medical training had not prepared them for dealing with marital problems.[2] Explanation may lie in part in the stigma any activity associated with sexual behavior has long borne.

* * *

MY PERSONAL experience of offering to teach a course on marriage in a medical school only to have the curriculum committee turn it down for lack of time contributes to this impression. However, I think that these accusations are in part unfair.

Among the several important reasons for the reluctance of medical schools to become involved in teaching of sex is that so little is really known about both its physiological and psychological aspects. What is often proclaimed as fact may in time be proven to have been a personal misconception or myth. In short, scientific knowledge about human sexual relations and abnormalities leaves much to be learned through future research.

This has been my own experience. Many statements about sex which I had read when first starting practice have been proven by clinical observation to have been fiction. For example, when I started in Psychiatry, I was taught that orgasm in the female is related to the psychosexual level of development. Thus, a mature, mentally healthy woman who had achieved a genital level of development should have a vaginal orgasm. The corollary was that a seriously mentally ill woman regressed to an oral level could not have a vaginal orgasm. Through the years I have seen this and other such myths exploded. I have seen the emotionally sickest of female patients report capacity for several consecutive orgasms—incidentally without relief of symptoms. Also I have seen women who were the epitome of emotional maturity in all other areas, incapable of vaginal orgasm.

Even today, despite our increased understanding in Psychiatry, there is still much confusion. At an all-day panel of the American Psychoanalytic Association which dealt with the specific symptom of female frigidity, considerable disagreement prevailed over the necessity for orgasm as an indication of a mature feminine response. The panel was finally able to conclude on a note of agreement over "the happy fact, so often denied, of the differences between the sexes."

* * *

THIS IS THE time to emphasize the main point of my presentation. I do not want to perpetuate new myths or misconceptions. I want the clinicians to also take what is said here about sex with a grain of salt. Check it out with your own clinical material. It may lead to discovering exceptions which really don't prove the rule.

With this precaution in mind, I can start my presentation of common sexual problems encountered in marriage.

Sexual intercourse, an activity much older than man, is misunderstood to an astonishing degree. One of the areas of ignorance is that of female frigidity. This was not important in eras such as the Puritan or the Mid-Victorian eras. But today a woman is expected, fairly or not, to be orgastic

## SCIENTIFIC PAPERS

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Doctor Martin is Clinical Professor in Psychiatry, Wayne State University, School of Medicine.

and thus is filled with anxiety and guilt if she is not. There are many contradictory positions proposed by so-called experts which contribute to such anxiety. In the human female, as different from lower animals, there exists the most marked liberation of erotic responsiveness from hormonal control.[3] Libido in the human female is relatively unaffected by the gonadal hormones; it is the psychic factor in the activation of erotic responsiveness that is decisive.

* * *

INABILITY TO achieve a vaginal orgasm is a very common disturbing sex problem in current American marriages. Now let us see what some "experts" have to say about this problem. Because of emphasis on vaginal orgasm as opposed to clitoral orgasm, many women have become unhappy because they reach an orgasm on clitoral stimulation only, never on vaginal stimulation.

To meet this anxiety, the authors of one book on sex in marriage therapeutically reassure these women by denying the existence of vaginal orgasm.[4] They argue that the vaginal mucosa is "not endowed with sensitive nerve touch-spots. . . . The vagina is made of the same kind of tissue that the intestines are made of. . . ." That when a woman attains an orgasm during vaginal coitus, it is not the vaginal stimulation, but rather the concommitant clitoral stimulation that produces the orgasm. "There can never be a purely vaginal orgasm. The argument as to whether an orgasm is vaginal or clitoral is much wasted breath."

Correct or not, this position serves a useful purpose. It relieves anxiety provoking pressure on those women who cannot achieve vaginal orgasm. It does not however, relieve the problem of those women who cannot achieve even a clitoral orgasm.

Another "expert" in reviewing this book takes exception.[5] He states, "The position of the authors in this matter is untenable, and their discussion will mislead and confuse the reader. In woman the vagina is the supreme organ of erotic sensation, but in order to respond adequately to vaginal stimulation, she must be properly prepared, or 'warmed up.' Preparation (foreplay) evolves not only physical measures (stimulation of erogenous zones, especially the clitoris) but also psychological measures. The husband it has been said must regard each act of coitus as a new act of seduction, with verbal expressions of his love and devotion. Many women think they are frigid because they cannot attain a vaginal orgasm, when really they are not frigid at all, the trouble being that their husbands, whether through ignorance or indifference, fail to arouse them."

This expert's contention is that if insertion is delayed by the husband until she is thoroughly ready and "can't wait any longer," she will respond with orgasm even if her husband ejaculates with the first thrust after insertion. This view certainly takes the pressure off the woman which is of value but now unfortunately and inaccurately puts it all on the man. What this expert fails to recognize is that the woman may have a defect in anticipatory excitement and puts all the pressure on participatory excitation.

Clinical material proves his view inaccurate. Some women cannot be gratified even if the man collapses in exhaustion from his efforts to please. They cannot achieve a clitoral orgasm. These women do not have the underlying vital fantasy that even conceptualizes an orgasm let alone an ego's executive capacity to bring the fantasy to fruition.

* * *

NOW, LET ME present the view of a third set of "experts" who give "the real truth about female sexuality."[6] They state that "Many women do not desperately need the release of sexual climax nor suffer its absence. They never achieve climax yet greatly enjoy every act of sexual intercourse, which gives them profound sensual and psychological satisfactions—the warmth of close embrace, the feeling of belonging, the pleasure of giving pleasure. The measure of sexual satisfaction for these women is a vast emotional complex of affection, tenderness, intimacy, the deeply feminine joy of serving her mate.

"This may sound simple.

"Actually it is revolutionary, for it points toward a completely new road to compatibility. It means that to be 'good in bed' Jane Doe need not reach that ecstasy in which the earth moves and the fireworks go off. (She must only) . . . relax and be a woman in the way that nature meant women to be. She need not be driven by tension, she need not find release in orgasm, to enjoy sexual relations with her husband."

* * *

AGAIN THIS view has merit, in that it takes pressure off the sexual situation. But it does not solve the problem of frigidity and the dissatisfaction of that type of husband who desperately needs an orgastic response from his wife and seeks it elsewhere. The "expert" quoted above took exception to this view too.[7] He states "The proposition that normal women fall into two classes, some capable and the rest incapable of orgasm, is untenable. It would be like saying that some people need oxygen while others can live without it."

I can only say that this gentleman's analogy is fallacious. The art of psychiatry still outweighs the science, and practitioners of the art disagree with each other more than is commonly recognized. Pertinent to this point is that as a so-called expert, I disagree with all three opinions stated above.

These contradictory positions illustrate the theme

Currently, accusations are made that sexual education of physicians is inadequate. There appears to be a reluctance in medical schools to include problems of sex and marriage in their curricula. One of the reasons that is stressed in this paper is that there is much myth and surprisingly little proven fact about the ubiquitous subject of sex. This paper exposes some of the myths and contradictory viewpoints related to sexual problems in marriage. The problems of frigidity, impotence, vaginismus and nymphomania are discussed.

of my presentation: the inadequacy of teaching about sex in medical schools and inadequate knowledge among physicians is, in part, explainable by how little information on sex is factually valid and how much is mythology and misconception.

The first author's attempt to take the emphasis away from vaginal orgasm by claiming it is clitoral is easily contradicted by women who do not have clitoral orgasm but who do have vaginal orgasm.

The critic who takes exception to this and then puts all the responsibility on the male for the female's orgasm is contradicted by innumerable case histories of women who can be stimulated by the hour clitorally and every other way and they are incapable of either clitoral or vaginal orgasm such as in nymphomania and prostitution. He ignores the psychic aspects of sexual adequacy and overemphasizes the physical stimulation.

The third group of experts describe the women who float in an atmosphere of feminine self sacrifice with pleasure but without orgasm. These must be the wives who don't complain and thus do not present themselves to physicians. I do think that there are some normal women who do not have orgasms without a psychological problem being responsible. I would guess that the percentage would be low but it should be recognized. There is a phylogenetic basis for this possibility in that in lower primates, sexual female behavior is a function of cyclic elaborations of gonadal hormones for the purpose of preservation of the species and not associated with orgasm or personal pleasure. In general, however, the human female is not of this type. In contrast, libido, or primary sexual urge in the human female is greatly affected by the fantasy life of the individual female.

* * *

THE NORMAL MALE and female sexual physiology is composed of two components which are operationally interdependent and presuppose one another. They are first, the somesthetic sexual stimuli or stimuli from sensitive parts of body as mouth, breasts and genitals, which then activates the second component—the sexual urge. But psychic factors play the determining role in the activation of human erotic responsiveness. The nature of the psychological factors which enter into identificational successes or failures are complex and variable but are related to overdetermined relationships existent between the developing child and one or both parents.

Thus many women enter into marriage somatically equipped but psychically unprepared for the sexual role which they must assume. Their primary obstacle to erotic responsiveness derives more from the area of sexual anticipation than from the area of sexual participation and that sexual anticipation is less a function of foreplay in the physical sense than of foreplay in the emotional sense.

Sexual urge is activated by **anticipatory** sexual excitation or imagination and the orgastic fulfillment of this urge by **participatory** or physical sexual excitation. In the presence of a high level of anticipatory excitement, there usually develops a proportionately high level of participatory excitation which culminates in a so-called vaginal orgasm. If anticipatory excitation which is psychic remains at sub-threshold levels, participatory excitation comes to depend less upon psychic cortical potentiation and more upon body stimulation. In such instances, the achievement or orgasm may require extra-coital stimulation of the clitoris—whence the term clitoral orgasm. Those individuals who are unable to develop high levels of anticipatory excitation are usually unable to do so as a result of innumerable types of psychological inhibitions.

* * *

LET ME DEVELOP the complexity of the problem by presenting to you some clinical material encountered by a gynecologist in his practice.[8] A patient consulted him regarding long-standing sterility which she felt was psychologically determined. She related her infertility to an almost phobic fear of motherhood which, she thought, derived from her fear of being the kind of mother to her children that her mother had been to her.

In this regard, she stated that childhood for her and her four sisters had been frightfully unhappy as a result of her mother's rejective and tyrannical behavior. She described her mother as having been an extremely morose individual who was aggressively contemptuous of both marriage and motherhood. When not disparaging her husband and her daughters, she was invoking the day when her husband would be dead and her daughters no longer her responsibility. In her brighter moments, she merely bemoaned the prospect of another pregnancy, or failing this, her past folly in ever having become pregnant.

This picture certainly shows what a noxious influence this mother was to her daughters. As her daughters grew older and left home, each pursued a course which would appear to be significantly related to the obviously defective mother-daughter relationship. One daughter became a practicing lesbian in Greenwich Village, one became a nun, one became an habitual aborter, one committed suicide and one became a sterility problem. They were all sexually disturbed.

* * *

WHILE THE foregoing example is gross, it illustrates in almost caricature form the variety, intensity and circuity of ways in which the feminine sexual role or one aspect of it may be renounced.

In this particular example, all five daughters, it would seem, were unable to affiliate themselves with the feminine sexual role as represented by their mother. These disaffiliative tendencies were most marked in the area of motherhood which each avoided either through the varied mechanisms of celibacy, homosexuality, and self destruction, or through the less obvious psychosomatic mechanisms of sterility and habitual abortion. It is such early parental influences which prevent sufficient anticipatory excitement needed to insure orgasm.

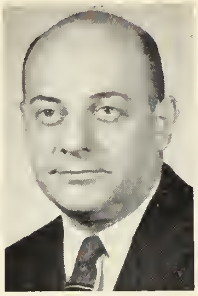
Other examples of fantasy affecting sexual behavior can be given.

Some women who idealize their fathers do not make the normal change of love object to their husbands and in fantasy feel disloyal to their father during the sexual act with their husbands. Women with penis envy may view sex as a contest which they must win through fantasied destruction of the husband's potency. Unconscious fear of pregnancy is a common cause of inhibition in female sexuality. Fears and misconceptions about sex transmitted by mothers is very common.

* * *

ANOTHER PROBLEM of sex in marriage is that of vaginismus which is generally of psychogenic origin. Usually vaginismus results from conscious or unconscious fear of being hurt by the man during the sexual act. Such fear, in turn, is related to the concept of "invasion" of the women's body, which underlies the phenomenon of frigidity. Essentially, frigidity is an expression of refusal to participate and cooperate in the sexual "invasion."

Nymphomania is occasionally encountered in practice. Such women are very sick, usually being borderline cases verging on melancholia and/or schizophrenia. Invariably they experience constant isolation, lonesomeness and longing, for which they seek sex as a fulfillment. Their efforts are in vain, since they are frigid and cannot achieve orgasm. They may report extreme sexual excitement—possibly due to a greater number of vaginal and clitoral nerve endings but the excitement is often that of anxiety and hostility discharged under the guise of sexual excitation.



THE AUTHOR

**Peter A. Martin, M.D.**

In the husband, the problems of premature ejaculation and impotence are often encountered. The same picture exists of sexual urge activated by anticipatory sexual excitation and the orgastic fulfillment of this urge by participatory sexual excitation. Here the end organ sensitivity comes from the genital corpuscles present in vast numbers in the glans penis. The genital corpuscles are intimately concerned with the reception and transmission of body sexual stimuli. Bilateral destruction of the ventro-lateral column in the spinal cord disrupts the transmission of these stimuli and results in loss of sexual urge. In contrast, postpolio paraplegia which involves a motor rather than sensory paralysis has no effect on sexual urge.

* * *

THE PSYCHIC factors are overwhelming in the male sexual difficulties of impotence and premature ejaculation. Fantasies are here again decisive. Fantasies particularly as they relate to sexual urge depend for their excitive pleasurableness upon a projected element of self-participation. When this element of participant involvement cannot be experienced in projection, fantasies, vitally needed, fail to develop *anticipatory excitation*—the condition indispensable to the development of the sexual urge.

The male as well as the female is prepared for his sexual role by his childhood relations to his parents. These experiences determine the fantasies which are the heart of anticipatory pleasure. The sexual problems of impotence and premature ejaculation as encountered by the male in marriage, have resulted in volumes having been written on this subject. Innumerable medical and mechanical remedies have been tried.

In general, such problems when referred to a psychiatrist are not as difficult to treat as cases of "frigidity" in the female. If a man is overcome by grief or seized by fear, he cannot attain an erection. Fear of any kind may prevent a satisfactory erection. These fears are usually unconscious in nature, needing psychotherapy to uncover.

Clinically, hostility is often the cause of the impotence. When so, it is surprisingly often (as compared with women) conscious in nature with revenge and punishment of the wife involved in the lack of erection. These are easily treated. Unconscious hostility to women may be deep rooted and resistant to therapy. Unconscious homosexual fantasies may prevent role identification and performance as a male.

Some men are able to be potent with women (other than their wives) whom they identify as "bad" and not with their wives whom they misidentify as "mother" who is good and pure and above sex. Or to have sexual relations with such a misidentified wife is considered incestuous and unacceptable. Men can be incapacitated sexually when their wives are pregnant, nursing, or when their children reach a certain age. These inhibitions are often triggered by a family situation which revives old forgotten childhood situations which were sexually disturbing to him. An unfortunate picture is that of the man who divorces his wife in order to marry the other woman with whom he is sexually adequate only to then experience the same sexual problem with his new wife.

* * *

IN CONCLUSION, so many contradictory opinions on sex are given because the innumerable unconscious fantasies in different people result in contradictory clinical pictures. It is for this reason that the danger to be avoided by physicians is the tyranny of the norm. By this I mean the danger is the presumption of fixed standards by which patients are rigidly measured and termed abnormal without full appreciation of the wide range of individual differences. A lack of appreciation of the wide range of individual differences can result in iatrogenically induced anxiety. I believe many doctors, feeling uncertain and anxious, have stayed away froim the area of sex until more reliable knowledge is available. But the physician's role in the management of sexual problems is expanding.

He is being forced to participate.

He must learn to objectively evaluate each patient for the specific underlying fantasies contributing to the presenting symptom. Psychiatric consultation and supervision should be used in the milder cases. The more severe problems will necessitate referral for psychotherapy.

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## Coming in June

"In June, watch for an important article on the importance of the selection of the patient for cancer chemotherapy. Much has been said about the choice of the proper cancer chemotherapeutic agent and this interesting paper by *Donald Korst, M.D.,* of St. Joseph Mercy Hospital, Ann Arbor, addresses itself to the choice of the proper patient.

In the same issue, *Raymond W. Waggoner, M.D.,* Chairman of the Department of Psychiatry and Director of the Neuropsychiatric Institute at the University of Michigan, discusses emotional factors in headache. *Charles Adams, M.D.,* formerly from Pittsburgh and now in Lansing, presents his classification of abnormalities of the thoracic wall; *Theodore Kilar, M.D.,* of Detroit reports two cases of complete rupture of the term gravid uterus, and *Ward Litton, M.D.,* of Ann Arbor, underlines important facts about the common affliction of serous otitis media.

# Electromyographic Effects Of Skeletal Muscle Relaxant Drugs In Paraplegia of Traumatic Origin

By Wayne W. Glas, M.D.,
and S. M. Baylis, M.D.,
Both of Eloise

## Introduction

Traumatic paraplegia is a disastrous condition. The care of the paraplegic patient presents numerous physical problems in addition to the serious mental depression that inevitably develops in the affected individual. Some of the complications of paraplegia are decubital ulcers, recurrent infections of the urinary tract, and severe muscle cramps and spasms that may lead to flexion contractures.

Rehabilitation is of the greatest importance in paraplegic individuals, some of whom can attain self care, ambulation, or even gainful employment. Progress in these directions, however, may be hampered frequently by muscle spasm and hypertonicity.

The possible usefulness of the skeletal muscle relaxant drugs in this condition is thus of considerable interest.

Unfortunately, the incidence of traumatic paraplegia is rising. In this institution alone, during 1962, there were 17 such cases, and the number has increased yearly over the past 10 years. The usual cause is injury sustained during a high-speed automobile accident. Damage to the spinal cord was found to be the third most frequent type of injury in these circumstances, exceeded only by injuries to the chest and the head.

A brief survey of the history of the skeletal relaxant drugs is in order before discussion of the present series of cases. More than a half century ago, Gilbert and Descomps[1] and Launoy,[2] noted that phenoxypropanediol induced a flaccid but transient paralysis in laboratory animals. It was not, however, until after the work of Berger and Bradley was reported in 1946[3] that consideration was given to the possibility of inducing muscular relaxation during light anesthesia. In 1951, Hermann and Smith[4] reported on the use of mephenesin in arthritis and other conditions associated with spasm of the skeletal musculature.

With the introduction of meprobamate in 1955,[5]

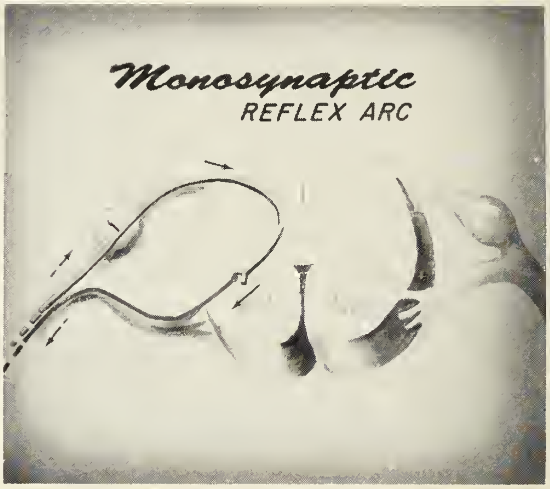
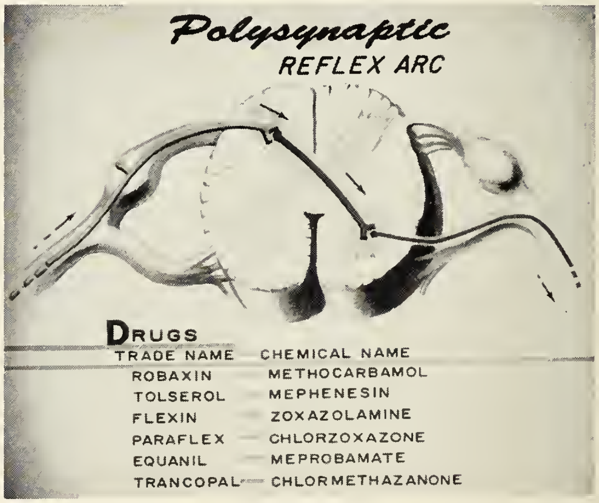


Figure 1

Schematic representation of a monosynaptic reflex arc. Such reflexes are protective and phylogenetically primitive and are supposedly not influenced by the skeletal muscle relaxant drugs.



| TRADE NAME | CHEMICAL NAME |
|---|---|
| ROBAXIN | METHOCARBAMOL |
| TOLSEROL | MEPHENESIN |
| FLEXIN | ZOXAZOLAMINE |
| PARAFLEX | CHLORZOXAZONE |
| EQUANIL | MEPROBAMATE |
| TRANCOPAL | CHLORMETHAZANONE |

Figure 2

Schematic diagram of a polysynaptic reflex arc. Such reflexes are cf more recent development than the monosynaptic reflexes (Fig. 1) and are secondary to them. Polysynaptic reflexes are generally supposed to be influenced by the skeletal muscle relaxant drugs.

---

From the Department of Surgery, Wayne County General Hospital, Eloise, Michigan.

**TABLE I. REPRESENTATIVE LIST OF SKELETAL MUSCLE RELAXANT DRUGS**

| Generic Name | Year Introduced | Trademark Name(s) |
|---|---|---|
| Carisoprodol | 1959 | Rela, Soma |
| Chlormezanone | 1960 | Trancopal |
| Chlorzoxazone | 1958 | Paraflex |
| Mephenesin | 1948 | Tolserol |
| Mephenesin carbamate | 1955 | Tolseram |
| Meprobamate | 1955 | Equanil, Miltown |
| Metaxolone | 1962 | Skelaxin |
| Methocarbamol | 1957 | Robaxin |
| Oxanamide | 1958 | Quiactin |
| Phenaglycodol | 1957 | Ultran |
| Phenyramidol HCl | 1960 | Analexin |
| Styramate | 1958 | Sinaxar |

new emphasis was placed on the muscle relaxant drugs, and many additional drugs were introduced in rapid sequence as shown in Table I. Pharmacological investigation with animals has indicated that the site of action of the skeletal muscle relaxant drug is on the polysynaptic reflexes of the spinal cord. Furthermore, some of these drugs are considered to be subcortical depressants and have received wide use as tranquilizers.[5]

Supposedly, monosynaptic reflex arcs (Figure 1), which are primitive and defensive, are not influenced by the skeletal muscle relaxant drugs.[5-8] The polysynaptic reflexes (Figure 2) are, however, of more recent origin and are secondary in function to the monosynaptic reflexes and are believed to be influenced by these drugs. In the polysynaptic reflexes, motor neurons above and below the level of sensory stimulation are activated by intermediate or internuncial neurons. The total effect is thus a more generalized motor response than is the case with monosynaptic reflexes.

In the paraplegic patient, this generalized motor response is exaggerated and results in the painful muscular spasms that characterize the condition. The present report concerns the comparative effect of two muscle relaxant drugs (mephenesin and methocarbamol)[9] and a barbiturate (secobarbital) on the electromyographic (EMG) responses of 14 paraplegic patients.

## Materials and Methods

### Patients

Fourteen male paraplegic individuals participated in the present study. The condition has been present in all patients for over one year. Most of these patients had become paraplegic as the result of injuries to the spinal cord sustained in automobile accidents. These patients were most suitable for investigation of the efficacy and site of action of skeletal relaxant drugs, not only because lesions of the kind exhibited by them abolish cortical effects, but because such patients frequently experience painful involuntary muscular spasms. The types and levels of the paraplegic lesions exhibited by these patients are shown in Figure 3.

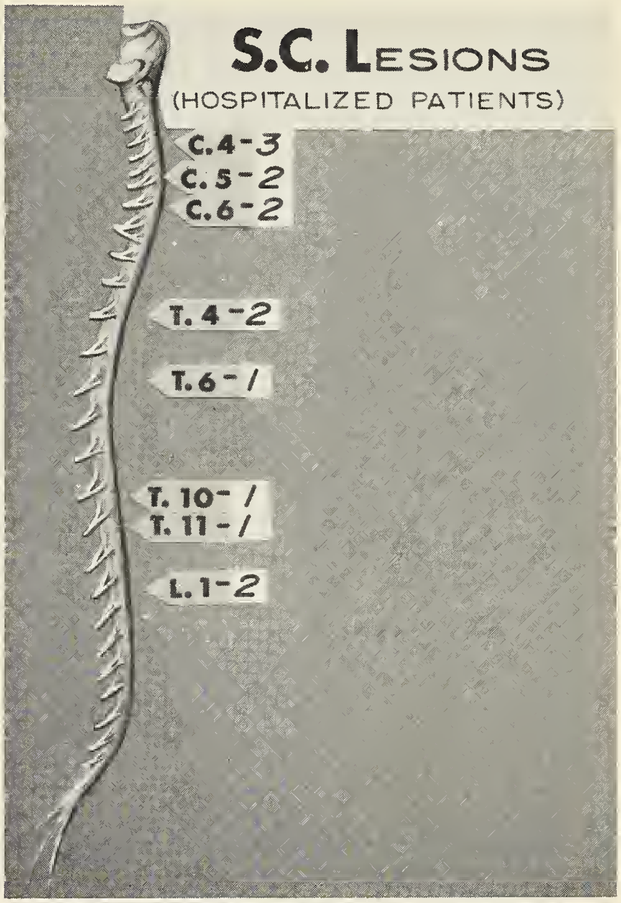
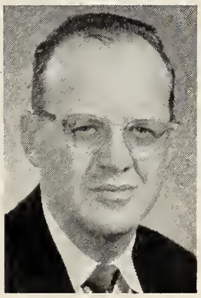


Figure 3
Types and levels of paraplegic lesions in the 14 patients who were the subjects of the present study.


Glas

Baylis

### Medications

Three medications were used in the present study. They were mephenesin (Tolserol), methocarbamol (Robaxin), and secobarbital (Seconal). In many instances, patients were tested at weekly intervals with different drugs. In this situation, the patient served as his own control. Sufficient time was allowed after the administration of any drug to ensure that the blood level was adequate.

### Procedures

Prior to the inception of the present study, all drugs with sedative effect were withheld from the

EVALUATION OF MUSCLE RELAXANT DRUGS BY ELECTROMYOGRAPHY

NAME__________ CASE NO.__________

DATE__________ DRUG__________ ROUTE__________ TIME ELAPSED__________

|  | RIGHT |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | LEFT |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
|  | Ham. |  |  |  |  |  | Quad. |  |  |  |  |  | Add. |  |  |  |  |  | Ham. |  |  |  |  |  | Quad. |  |  |  |  |  | Add. |  |  |  |  |  |
|  | Before |  |  | After |  |  | Before |  |  | After |  |  | Before |  |  | After |  |  | Before |  |  | After |  |  | Before |  |  | After |  |  | Before |  |  | After |  |  |
|  | A | F | D | A | F | D | A | F | D | A | F | D | A | F | D | A | F | D | A | F | D | A | F | D | A | F | D | A | F | D | A | F | D | A | F | D |
| RESTING |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| BABINSKI OR STROKE DORSUM OF FOOT, LEFT |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| LEFT ACHILLES REFLEX |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| LEFT PATELLAR REFLEX |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| RIGHT ACHILLES REFLEX |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| RIGHT PATELLAR REFLEX |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| BABINSKI OR STROKE DORSUM OF FOOT, RIGHT |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| THREAT |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| OTHER |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Figure 4

Work sheet used in the present study. To complete each of these sheets, 324 EMG observations were made. One such sheet was completed for each patient.

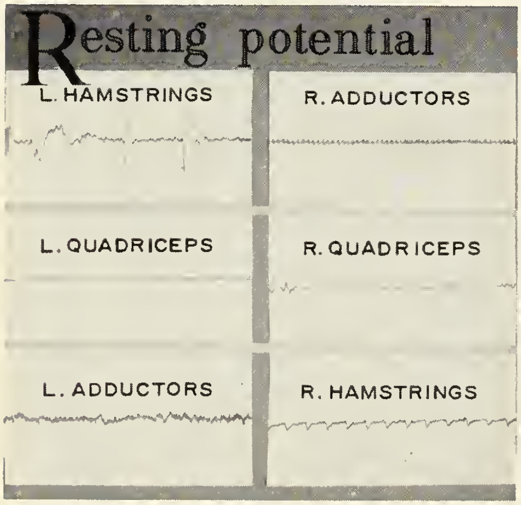


Figure 5

Typical example of EMG findings in a resting paraplegic. With the patient supine, EMG recordings were made of the effects of 3 stimulations: (1) sensory stimulation of the dorsum of the foot, (2) Achilles tendon reflex, (3) patellar reflex.

TABLE II. SUMMARY OF EMG FINDINGS BEFORE AND AFTER DRUG ADMINISTRATION

|  | Results |  |
|---|---|---|
|  | Monosynaptic | Polysynaptic |
| Tolserol | 1+ | 1+ |
| Robaxin | 1+ | 1+ |
| Seconal | 2+ | 2+ |

1 + Slight Decrease in Motor Activity
2 + Moderate Decrease in Motor Activity

patients for from 7 to 10 days. The patients were placed in a quiet room in which the EMG studies were performed under standard conditions. EMG observations were taken with a Grass-Polygraph Model 5A; this is a 6-channel device that permits simultaneous recordings from 6 separate muscle groups. At weekly intervals, resting potentials were obtained from the 3 following muscle groups: (1) hamstrings, (2) quadriceps, and (3) adductors, bilaterally.

The work sheet used is shown in Figure 4. To complete this form, 325 EMG observations had to be recorded. Since one of these work sheets was prepared for each of the 14 patients in the series, more than 4500 EMG observations were recorded in the course of the present study.

Observations were made with the patient in the supine position, first without medication, then after the administration of 1 of the 3 drugs. In every case, EMG recordings were taken of the opposite adductors upon elicitation of the knee jerk, and of the opposite quadriceps during the Babinski reflex (Figure 5).

## Results

Table II summarizes the EMG findings in all 14 of these patients before and after the administration of the three drugs under investigation. Comment upon several typical cases follows.

Figure 6 shows the comparative EMG recordings taken before and after the intravenous administration of 1 gm. mephenesin. It can be seen that the

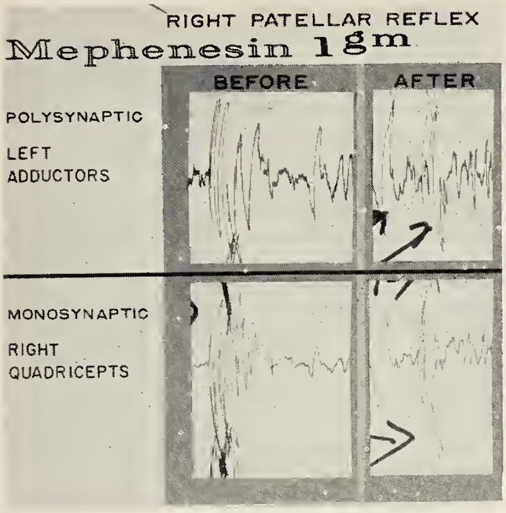


**Figure 6**
**Comparative EMG recordings before and after the intravenous administration of 1 gm. mephenesin. Note the decrease in duration of EMG response associated with the monosynaptic patellar reflex. There was also a decrease in the duration of the polysynaptic reflex to electrical stimulation of the opposite adductor muscle.**

drug induced a decrease in the duration of the EMG response associated with the monosynaptic patellar reflex. There was *also* a decrease in the duration of the EMG response of the polysynaptic reflex in the opposite adductor muscle.[5,6]

There is a slight decrease in the amplitude frequency and duration in the ipsilateral quadriceps. In the opposite quadriceps, however, the EMG response also indicates a slight suppression of a polysynaptic reflex.

EMG response before and after the intravenous administration of 1 gm. methocarbamol is shown in Figure 7. Note that, after the drug had been given, there was a general decrease in the duration of the EMG response of both the left and right quadriceps muscles to the left patellar reflex. Also there is a decrease in the frequency of response in both muscles.

Figure 8 shows the relative durations of the EMG response before and after the intravenous administration of secobarbital. It can be seen that this drug induced a decrease in duration and frequency in the EMG response following induction of the right Babinski reflex.

The most common undesirable effects of these drugs were weakness, lethargy, and sleepiness. These side effects can be attributed to the cerebral depressant effects of the three medications.

## Comment

The EMG data obtained in the present study of 14 paraplegic patients show no marked difference in the effects produced by the two so-called skeletal muscle relaxant drugs (mephenesin and methocarbamol) and those induced by the barbiturate (secobarbital). Furthermore, no evidence was adduced that would indicate the existence of any selective depression by any of these agents of the polysynaptic reflexes over the monosynaptic reflexes.

The authors are of the opinion that the so-called skeletal muscle relaxant drugs are, in humans, central nervous system depressants not unlike many other medications known to the medical profession for many years. It has been their experience, as illustrated by the study reported here, that these new drugs are of limited value in the management of paraplegia.

## Summary

The increasing incidence of paraplegia of trau-

*(Continued on Page 341)*

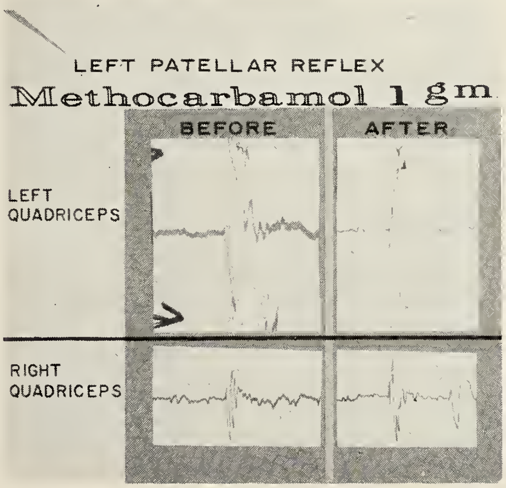


**Figure 7**
**EMG response before and after the oral administration of 1 gm. methocarbamol. Note the generalized decrease in the duration of the EMG response to the left patellar reflex.**

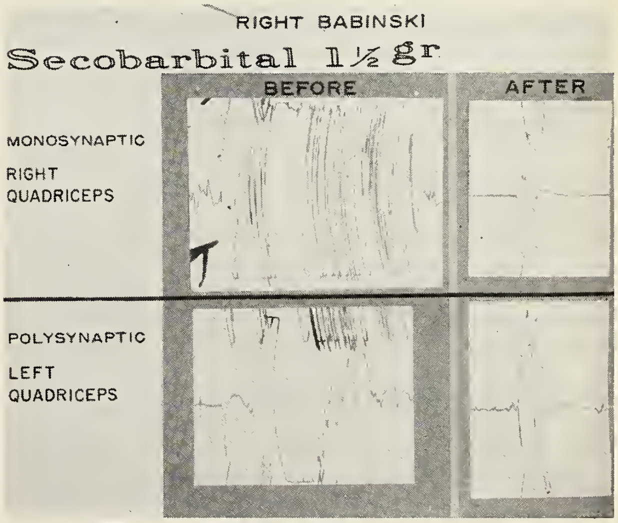


**Figure 8**
**EMG response after the administration of secobarbital. Note the significant generalized decrease in response following the Babinski reflex in the right foot.**

***. . . It shouldn't happen today, but it does . . .***
***. . . The answer lies with many individuals and institutions . . .***
***. . . Physicians . . . have been apathetic . . .***
***. . . Solution . . . lies in education . . .***
***. . . We must be interested in . . . quality . . .***

# The Physician's Responsibility in Family Planning and Population Control

By J. Robert Willson, M.D.
Ann Arbor

It may seem incongruous for obstetricians to be concerned with controlling reproduction but actually it makes good sense.

This is a serious problem.

If the production of people continues at its present rate, the population of the world will double, to 6 billion by the year 2000; by 2600 there will be 1 square yard of surface per person, by 3600 the weight of the people will equal the weight of the earth, and by 7200 people will be expanding into space with the speed of light.

Obviously this is not likely to happen but it does illustrate the rapidity with which we are reproducing.

> *It has been suggested that this is no serious problem because of all the available area on other planets to which people can be transported. At the current rate of growth we would have to dispatch 7000/hour at a cost of $500 billion/day to maintain a stable population.*

We in this country are prone to think of the population increase as a problem which affects Africa, Asia, South America and other distant countries rather than our own. We overlook the fact that the rate of annual increase in the population in the U. S. doubled between 1940 and 1959. In addition, during the same time the number of 5th children increased by 73 per cent, of 6th and 7th by 62 per cent and of eight or more by 22 per cent. The total number of marriages in this country in 1958 was 1,465,000 and in 1962, 1,579,000. The number of children under age 10 increases each year.

Because many of these children are born into low income families, this is an extravagance we cannot afford.

In 1960, 20 per cent of all American children lived in families with incomes less than $50/week for four people.

* * *

IN NEW YORK City multiproblem social families, some known to as many as 20 agencies, averaged four times the number of children per family as the rest of the families in the city. It has been predicted that by 1965 almost half the children born in New York City will be to indigent families.

In a large eastern city one year ago (1963), there were 66,000 dependent children costing the community about $3 million per month. In the same city there were 22,000 in 1953, and in 1932 only 6,000; the total population is about the same. Non-white individuals make up slightly less than 30 per cent of the population, but provide about 40 per cent of the births. Only about 40 per cent of children in this community finish high school.

Remember the dramatic story of Margaret Sanger and the incident which stimulated her to establish the Planned Parenthood organization. As a public health nurse she attended a woman seriously ill from an induced abortion. She recovered, but a year later Mrs. Sanger again cared for her as she died from another.

> *This was in 1916 and shouldn't happen today, but it does. During 1963 about ⅓ of the maternal deaths in Pennsylvania followed induced abortion. Most occurred in married women and represent their attempts at limiting family size. The same*

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Doctor Willson, Department of Obstetrics & Gynecology, University of Michigan Medical Center, Ann Arbor, Michigan.

> *situation is true in Michigan and other states. Most women survive induced abortions, but many suffer physical and emotional injury which may impair their health permanently.*

Loss of life is important, but the cost of caring for a woman seriously ill with an induced abortion is unbelievable. They need expensive medications, multiple transfusions, daily laboratory studies, operations, renal dialysis, etc. In the Temple University Hospital this averaged $3,000 and in one who died the cost was almost $6,000.

* * *

HOW WONDERFUL IT would be if the need to control family size by abortion were eliminated and the cost of caring for these women could be diverted to the care and education of their children.

Four-fifths of all married couples in this country either have used or intend to use some method for controlling fertility. Fifteen per cent of all married women want fewer children than they have. Seventy per cent of women enrolling in prenatal clinics had not planned the present pregnancy.

In a study of 18 families on relief in an Ohio county there was a total of 119 children. Of these 119, 75 had been born after the county began to support the families. The total number of children the families *wanted* was 60. The additional cost to the county of the children born after the families went on relief approximated $150,000.

If the desire for fertility control is so universal, why is it not more readily available? The answer lies with many individuals and institutions.

> *Politicians at national, state and local levels are not often willing to face up to the population problem because a firm stand on either side will influence voters. As a predictable consequence of this reticence, state and local welfare workers often are specifically forbidden to broach the subject of contraception to their clients, even those who need it most.*

The administrators of city and county hospitals and those which are partly supported by governmen funds are concerned about their appropriations. In an attempt to avoid controversy and criticism they often sidestep the issue of family planning clinics. Some prohibit them without question while others are more evasive, using excuses such as lack of space, time, help, etc., to avoid an outright refusal. Actually such clinics should improve budgetary status by reducing the load of indigent obstetric patients who, with their premature infants, often require long-term hospital care.

* * *

PHYSICIANS, WHO SHOULD have the greatest interest in the problem and play a leading role in its solution, have been apathetic. Many avoid the subject completely because (1) they are not interested, (2) they fear that they will become involved in troublesome legal and religious issues and (3) because of a presumed moral issue.

A recent survey of physicians in various areas of this country revealed some interesting facts which suggest that many of them, even obstetrician-gynecologists, attempt to disregard the whole subject of contraception.

1. Over ⅔ of the non-Catholic doctors surveyed thought the birth-control information should be provided *only* when it was requested by a patient.
2. Of those who professed to premarital counseling, only ⅓ brought up the subject of contraception *often* and almost half *never* mentioned it voluntarily.
3. About half stated that they *never* initiated a discussion of contraception with women they had delivered.

The universities are at least partly responsible for the attitudes of their graduates.

> *Family planning, except that related to infertility, if mentioned at all, is often discussed in a single whole class lecture and no time is devoted to the social and economic aspects of population growth. Few departments of obstetrics and gynecology include in their curricula lectures, conferences or seminars in which marital counseling, family planning and sexual problems in general are considered more than superficially.*

Medical education has been directed toward teaching an individual physician to deal with the personal problems of an individual patient, often without regard to the impact of the problem upon other members of the family or on the community.

* * *

FOR EXAMPLE, the right of a chronically indigent woman of low mentality to reproduce without control often is considered to be "sacred." We are loath to terminate her fertility even though each year she adds another child to the community relief rolls. We use excuses such as "some day she

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may want to marry and to have a baby with her husband," ignoring the obvious fact that this baby also will become a public charge. The individual physician is not entirely responsible for this attitude; since he has never been taught to consider problems confronting groups of people, he is not used to thinking in these terms.

> *The solution is not easy, but it lies in education rather than in wholesale sterilization and abortion. It will take time, but unless a widespread program is initiated promptly it may be too late. Every member of the population, not just a selected few, must be made aware of the problems confronting us.*

Those of us who are responsible for the obstetric-gynecology training of young developing physicians must devote much more time than we ever have to sex education in its broadest sense. Not just contraception.

This includes making young doctors conscious of their responsibilities to the community as well as to individual couples with sexual problems. This is far more important for the senior medical student to know than are the mechanisms of labor in breech presentation and the contraindications to hysterectomy.

* * *

WE MUST BECOME aware of the problems in our own communities and support the organizations which are attacking them. We should provide the motivating force for the development of more adequate programs for sex education in the schools, churches and other organizations. There are many other areas for our leadership and participation.

**Premarital Counseling:** The value of a good premarital program is unquestioned. Many misunderstandings can be corrected and many emotional problems can be eliminated or avoided before they become permanent deterrents to a satisfactory family relationship.

**Marriage Counseling:** This also is a productive area of family service. Most physicians are not properly equipped to provide good marital counseling, but they can learn. If there are no facilities available or if they are inadequate their expansion is necessary.

**Infertility:** Twenty-three per cent of women want more children than they can have. It may sound inconsistent to develop a program for the study and correction of infertility when we are so concerned about the population increase, but it actually is not.

> *Our concern is not solely that quantity be reduced, we must also be interested in improving the quality of the population. If we can help responsible, intelligent, infertile couples of all races to reproduce while we are reducing the birth rates of less desirable citizens, we are rendering an important service to the community, the world community as well as the local.*

A program of population control alone is not adequate. The people who benefit most from it, those in the lower socio-economic groups, need a considerable amount of education and rehabilitation before they and their children can even approach the status of "solid citizens." Money must be made available for this purpose. Unless these people are properly educated and motivated, the outlook for urban communities is almost hopeless.

I realize that this is an ambitious program and perhaps it may appear to be impossible. As more and more people become concerned about the economic and social problems which are expanding with the population more will become interested enough to do something about it.

If we physicians, the acknowledged experts in the field of reproduction, are not willing to take the lead in this essential cause, who will?

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# Chronic Arthritis and Heart Disease

By Leon D. Ostrander, Jr., M.D.
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Rheumatoid arthritis and ankylosing spondylitis are systemic diseases with important visceral manifestations. During the past 20 years specific cardiac lesions have occasionally been identified in each condition.

In 1944, Baggenstoss and Rosenberg[1] discovered a rheumatoid granuloma in one cusp of the aortic valve of a patient who had died with rheumatoid arthritis. Other reports of aortic or mitral valve damage by rheumatoid granulomata followed.[2,3]

In 1951, Bauer, Clark and Kulka[4] reported a distinct form of aortitis which was occasionally observed in persons with ankylosing spondylitis. This lesion involved the aortic valve ring and a short segment of the adjacent aorta and resulted in significant aortic regurgitation. On microscopic examination the elastic media was damaged by a vasculitis similar to that of syphilis.

Recently, Zvaifler[5] has called attention to a type of chronic joint disease which may follow acute rheumatic fever, so-called Jaccoud's arthritis. The distinguishing features of this condition are severe rheumatic fever with repetitive or prolonged attacks and delayed recovery, followed by residual metacarpophalangeal joint swelling and stiffness and ulnar deviation due to periarticular fascial and tendon fibrosis. Such patients have little synovitis or signs of inflamation and the sedimentation rate and tests for rheumatoid factor remain negative.

* * *

IN ADDITION TO these uncommon examples of heart disease and chronic arthritis as manifestations of a single disease, some investigators have reported the frequent occurrence of other cardiac abnormalities in autopsied patients with rheumatoid arthritis. Baggenstoss and Rosenberg[6] reported evidence of rheumatic valvulitis in 14 of 25 patients. Clark and Bauer[7] found valvular disease in 20 per cent and pericarditis in 44 per cent of 445 patients with rheumatoid arthritis. Many of these lesions were minor and undetected during life. Other investigators have reported similar postmortem findings.[8,9]

Classification of acute arthritis may be difficult, particularly when there are signs of heart disease. Juvenile rheumatoid arthritis has frequently been diagnosed as rheumatic fever and even in adults the distinctions are not always clear. Rheumatic fever in the adult may mimic early rheumatoid arthritis with symmetrical involvement of the small joints of the hands.[10] Such attacks occasionally last for many weeks but do not produce permanent joint changes.

Four patients with arthritis and valvular heart disease are presented as examples of certain of these conditions.

## Case Reports

### Case 1

D. Z. was a 25-year-old white woman who had the onset of joint pain at six years of age. At first the symptoms were episodic and limited to the large joints, but by the age of 15 the disease had progressed to severe, crippling rheumatoid arthritis. At that time and for several years afterward, examiners reported a soft, blowing systolic murmur over the precordium, but no diastolic murmur was heard and the heart was not enlarged. At 23, slight cardiomegaly was detected and moderately loud aortic systolic and diastolic murmurs were heard. The blood pressure was 148/78. During the next several years the heart enlarged, the diastolic murmur became louder and the pulse pressure widened until the blood pressure was 150/40. Mild congestive heart failure was treated with digitalis and diuretics and occasional espisodes of angina pectoris were relieved by nitroglycerin. The arthritis did not change in severity while the signs of heart disease developed. Although the spine was involved, the major deformities were in peripheral joints and were characteristic of rheumatoid arthritis. There were no signs of ocular damage by rheumatoid granulomata. The sheep cell agglutination test for rheumatoid factor was positive.

Various therapeutic regimens which included salicylates, gold, adrenal steroids, phenylbutazone and physical therapy provided no lasting benefit.

## Comment

This patient never had evidence of rheumatic fever, lupus erythematosus or syphilis. The progressive destruction of the aortic valve was probably related to rheumatoid arthritis. The precise lesion, whether granuloma, nonspecific valvulitis

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or aortitis, is unknown because it was not possible to maintain contact with the patient.

## Case 2

O. H. was a 48-year-old man who had experienced pain and stiffness in the back for 20 years. At 38 the condition was diagnosed as ankylosing spondylitis and he was treated with radiation to the spine. There was no history of heart disease, rheumatic fever or syphilis.

On physical examination there was complete fixation of the lumbodorsal spine, decreased chest expansion and limited rotation of the neck. The heart was at the upper limits of normal in size and a loud aortic diastolic murmur was heard. The blood pressure was 135/60 and the remainder of the physical examination was normal.

The chest x-ray and electrocardiogram suggested left ventricular enlargement. The blood Kahn test for syphilis was negative. X-rays of the spine revealed the characteristic changes of ankylosing spondylitis.

### Comment

This patient had been examined many times during the course of his illness and it is unlikely such a loud murmur would have remained undetected. The aortic insufficiency probably developed recently as a result of aortitis of the type described by Bauer, Clark and Kulka.[4]

## Case 3

L. H. was a 39-year-old white man who vaguely recalled an episode of pain and swelling of the knees and ankles at the age of 20. The symptoms subsided spontaneously and he was well until the age of 36 when he again had pain and swelling of the knees and ankles. This attack and two subsequent episodes each lasted less than two weeks. Six weeks before admission to the hospital his symptoms recurred but for the first time he noted pain, swelling and stiffness of the hands. He had never been told of a heart murmur.

On physical examination the metacarpophalangeal and proximal interphalangeal joints of both hands were swollen, warm and tender. Nodules were palpable along the ulnar surfaces of the forearms and there was a faint erythematous rash on the trunk. A loud mitral diastolic murmur was heard but the heart was not enlarged and there were no signs of congestive heart failure. The remainder of the physical examination was unremarkable.

L. E. cell tests and sheep cell agglutination tests for rheumatoid factor were negative on two occasions. The sedimentation rate was 33 millimeters per hour, the C reactive protein 4+ and the antistreptolysin 0 titer 500 Todd units. These values returned to normal after several months. Microscopic examination of a biopsied nodule revealed the characteristic features of a rheumatoid granuloma.

Treatment with salicylates resulted in moderate improvement at first, but over the next six months, active synovitis continued and the signs of rheumatoid arthritis became more definite.

### Comment

At first the differential diagnosis included active rheumatic fever, rheumatoid arthritis and post-rheumatic fever arthritis. Although the response to salicylates and the laboratory data suggested rheumatic fever at one time, the histologic features of the biopsied nodule and the subsequent course of the disease clearly established the diagnosis of rheumatoid arthritis. The mitral stenosis probably resulted from an earlier attack of rheumatic fever.

## Case 4

E. W. was a 39-year-old white woman who developed pain and swelling of both ankles followed by pain, swelling and stiffness of the hands a few weeks before admission to the hospital. The ankles returned to normal in a few days but the hands did not improve. She had never been told of a heart murmur and there was no history of a recent respiratory infection.

On physical examination the metacarpophalangeal and proximal interphalangeal joints of both hands were swollen, warm and tender and she had difficulty making a fist. The heart was not enlarged but mitral systolic and diastolic murmurs were heard. The remainder of the physical examination was unremarkable.

The sedimentation rate was 30 millimeters per hour, the C reactive protein 5+ and the antistreptolysin 0 titer 625 Todd units. Two L. E. cell tests and a sheep cell agglutination test for rheumatoid factor were negative.

The arthritis did not improve with salicylates

Distinct valvular heart lesions are occasionally encountered in persons with rheumatoid arthritis or ankylosing spondylitis, while in rare instances a form of chronic arthritis may follow acute rheumatic fever. Such associations are unusual and most patients with rheumatoid arthritis or ankylosing spondylitis and valvular heart disease probably had prior rheumatic fever.

so adrenal steroids were added to the regimen. Over the next three months the arthritis gradually subsided and the joints returned to normal. The heart murmurs did not change. At the end of this period the sedimentation rate was 9 millimeters per hour, the antistreptolysin 0 titer 333 Todd units and the C reactive protein negative.

## Comment

This patient probably had an unusual manifestation of rheumatic fever, although this episode would be compatible with an initial attack of rheumatoid arthritis. The damage to the mitral valve could have resulted from this or an earlier attack of rheumatic fever.

## Conclusions

Chronic arthritis and heart disease are clearly associated in three uncommon conditions.

Patients with rheumatoid arthritis may develop valvular heart disease as a result of rheumatoid granulomata. Such patients usually have severe arthritis, subcutaneous nodules, ocular damage from granulomata and high titers of rheumatoid factor.

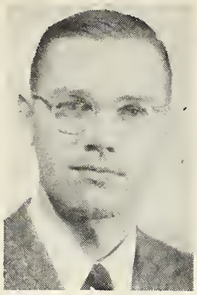
Occasional patients with ankylosing spondylitis have aortic regurgitation as a result of degeneration of the elastic media near the aortic valve.

Chronic arthritis of the metacarpophalangeal joints is a rare complication of severe or recurrent rheumatic fever. This condition is characterized by periarticular soft tissue swelling and ulnar deviation without synovitis or other evidence of inflamation. Such patients invariably have rheumatic heart disease.

In addition to these specific but unusual associations of valvular heart disease and chronic arthritis, some investigators[6-9] have reported a high frequency of rheumatic valvular disease and pericarditis at autopsy in patients with rheumatoid arthritis.

Autopsy findings are unavoidably biased and if valvular disease and pericarditis are more frequent in rheumatoid arthritis, it is surprising that such associations among living patients have seldom been reported.[11] Perhaps many of the lesions are too minor for clinical detection. It seems likely that most patients with rheumatoid arthritis and detectable valvular heart disease probably had prior rheumatic fever.

The precise diagnosis of a patient with acute arthritis and a heart murmur requires a detailed history, careful physical examination and in some cases prolonged observation. The various laboratory tests are helpful but lack sufficient specificity to be decisive factors in classification.



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## *Score One for the Men!*

Things are looking up in the worn but rather pleasant man-woman tug-of-war over who's better at what. The Health Insurance Institute reports that even though the women live an average of seven years longer than men, the men are, in the final analysis, better at resisting disease.

Only in the injury category are the men more susceptible than the women, the Institute reports, admitting that perhaps the men do lead more physically active lives.

# Oxyphenbutazone Versus Enzymes In Rhinoplasty
## A Clinical Study

By Khalid M. Durrani, M.B., F.R.C.S.(C)
C. Jack Hipps, M.D., and Ruy Vianna, M.D.
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In a recent study from our Clinic,[1] the usefulness of Tandearil[*] as a routine anti-inflammatory agent in certain plastic surgical procedures was presented. While this drug continues to be a satisfactory therapeutic adjunct in our hands, there are certain definite contra-indications to its use. Among these are cardiac decompensation, blood dyscrasias, and peptic ulcer.[2] Since the elimination of postoperative tissue edema is extremely desirable for a good functional and cosmetic result, the need for a safe and effective agent that would aid in the attainment of this objective continues to be apparent.

The object of the present study was to try a relatively innocuous agent (Chymoral)[†] from amongst a host of other drugs that are being used for this purpose and to compare its effectiveness with that of Tandearil. To eliminate the variable of the type of surgical procedure, only one, rather common, plastic procedure, viz., rhinoplasty, was selected for study.

Certain observations made during this study provide the basis for this article.

## MATERIAL AND METHODS

Fifty consecutive cases of primary rhinoplasty, with no previous nasal surgery or recent nasal trauma, were included in this study and alternate cases were given Chymoral or Tandearil according to the following routines:

> "Tandearil Routine": 200 mg. t.i.d. day before and day of surgery, 100 mg. q.i.d. subsequently.
>
> "Chymoral Routine": ii tab. t.i.d. day before surgery; ii tab. q.i.d., postoperatively.

In two patients on Tandearil, the drug was discontinued early in the course of treatment because of gastric upset. These were excluded from the study. On all other cases, observations were made daily until the fourth postoperative day, when the majority of the patients were discharged.

A separate series of ten controls was also established and fulfilled the same requirements as the treated group except that the anti-inflammatory drugs were omitted in the controls.

Three variables were examined in each case. The first one was the "per cent change in the orbital fissure size." The distance between the upper and lower eyelash borders was measured and the average of the two sides was recorded as the "fissure size." The minimum size attained postoperatively, on any day, was used in the calculation of the maximum per cent change with reference to the admission size.

The second variable studied was the "facial swelling." It was an expression of the edema and ecchymosis of the face as a whole. A "plus system" with three categories was used. "Three plus" was recorded when the swelling was extreme, with the eyes practically swollen shut and the eyelids hardly moveable. "One plus" implied no noticeable swelling or a minimal ecchymosis, confined to the eyelids, and "two plus" constituted all of the remaining majority with intermediate degrees of swelling. The "plus" signs of the four postoperative days for each case were then added and recorded as the "facial swelling" for that particular case.

The third factor was that of the "number of narcotic doses" administered postoperatively during the four days. One narcotic dose was equivalent to 100 mg. Demerol intramuscularly, or two tablets of Salatin with Codeine (Ferndale Surgical)[*] orally.

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[*] Tandearil is oxyphenbutazone (Geigy).

[†] Chymoral (Armour) is an oral enzyme preparation with trypsin and chymotrypsin activity.

[*] (i tab. Salatin with Codeine-Codeine phos.: 32.4 mg., Acetylsalicylic acid: 259 mg., Acetophenetidine: 130 mg., Caffeine: 16.2 mg.)

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TABLE I. SEX AND AGE DISTRIBUTION

| | Male | Female | Average Age | (1) 19 and under | (2) 20-34 | (3) 35 and over |
|---|---|---|---|---|---|---|
| Control | 3 | 7 | 30.4 | 2 | 6 | 2 |
| Treated | 9 | 41 | 29.8 | 12 | 20 | 18 |
| Chymoral | 5 | 20 | 31.3 | 4 | 11 | 10 |
| Tandearil | 4 | 21 | 28.4 | 8 | 9 | 8 |

TABLE II. INFLUENCE OF SEX

| | % Fissure Change | | | | Face Swelling (+) | | | | # Narcotic Doses | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Control | Treated | Chymoral | Tandearil | Control | Treated | Chymoral | Tandearil | Control | Treated | Chymoral | Tan. |
| Male | 55.9 | 47.3 | 46.8 | 47.8 | 6.3 | 6.0 | 6.0 | 6.0 | 3.33 | 3.66 | 4.00 | 3.25 |
| Female | 58.5 | 50.1 | 53.9 | 46.5 | 7.1 | 5.7 | 5.6 | 5.9 | 4.57 | 3.92 | 5.40 | 2.52 |

TABLE III. THE AGE FACTOR

| Age Group | % Fissure Change | | Face Swelling (+) | | # Narcotic Doses | |
|---|---|---|---|---|---|---|
| | Chymoral | Tandearil | Chymoral | Tandearil | Chymoral | Tandearil |
| Group I (19 years or less) | 47.5 | 40.9 | 5.7 | 5.4 | 5.25 | 3.00 |
| Group II (20-34 years) | 51.2 | 56.0 | 5.4 | 6.0 | 5.36 | 2.66 |
| Group III (35 years and above) | 55.9 | 42.2 | 6.0 | 6.2 | 4.80 | 2.00 |

No other narcotics were used and any analgesics that were used were not taken into consideration for the purpose of this study.

## RESULTS

### Sex:

There was a total of nine male and 41 female patients in the treated series and three males and seven females in the control series. The sex distribution was about the same in the Chymoral and the Tandearil groups (Table I). The males in the Chymoral series showed less change in "fissure size" compared to the females (46.8:53.9), Table II, and also had a smaller narcotic requirement (4.0:5.4). However, they showed a slightly greater facial swelling than the females (6.0:5.6).

In the Tandearil group, on the other hand, the facial swelling was practically the same in the two sexes (6.0:5.9) but the males showed a slightly greater change in "fissure size" (47.8:46.5) and required more narcotics than females (3.25:2.52), Table II.

In the control group, the females showed a greater facial swelling, greater change in the orbital fissure and required more narcotics postoperatively than their male counterparts.

### Age:

The overall average age of the controls was 30.4 years and that of the treated group 29.8 years, with the Tandearil group averaging about three years younger than the Chymoral group (28.4:31.3), Table I. The treated groups were divided arbitrarily into three sub-groups (Table I).

Chymoral showed a progressively increasing "change in fissure size" with increasing age (Table III), but had no consistent effect on either the facial swelling or the narcotic requirement with reference to age.

With Tandearil, no consistent effect was noted on "fissure size" but facial swelling increased progressively with age (Table III). Narcotic requirement diminished progressively with increasing age in the Tandearil group.

### Antibiotics:

A total of 18 patients in the treated group received antibiotic therapy postoperatively. Of these, ten were in the Chymoral and eight in the Tandearil group. Surprisingly enough, a greater change in fissure size and a more marked facial swelling was noted in the group that did receive the antibiotics than in those that did not. This was true of both the Tandearil and the Chymoral groups (Table IV). The narcotic requirement, however, was reduced somewhat when the antibiotics were used. Even though the antibiotics were used mostly on cases where a foreign material, e.g., a pin, had been introduced, this factor, *per se*, did not seem to affect the three parameters one way or the other.

### Additional Procedures:

The last factor to be analysed was that of the additional procedures performed simultaneously with the routine rhinoplasty, which includes, in our clinic, a partial submucous resection of the septum. Several patients received additional minor procedures in and around the nose which could be

Sixty cases undergoing rhinoplasty, ranging in age from 15 to 63 years, were followed postoperatively in order to determine the comparative efficacy of two of the so-called "anti-inflammatory agents." Ten of these cases served as controls while the remainder were given either "Chymoral" or "Tandearil" according to a specified dosage schedule. On the basis of certain objective clinical criteria it was found that both agents had some beneficial effect on postoperative tissue response. While "Tandearil" was noted to be considerably more effective than "Chymoral," the latter was better tolerated by the stomach.

classified into two categories as shown in Table V.

Any individual procedure had no consistent effect on the three parameters studied and, therefore, the results of this variable will not be presented. Results were, however, classified according to the number of these procedures, regardless of the type, and are presented in Table VI. Again, no consistent effect was noted either with Chymoral or with Tandearil on the three parameters on this account. Considering the combined results of the two treated groups, when no additional procedure was performed, the change in fissure size and facial swelling was more than when any one or more of these procedures was combined with the standard rhinoplasty. Also, the narcotic requirement was considerably more in the former group (5.14:3.63). The same trend was observed in the control series in the matter of facial swelling and orbital fissure size but the narcotic requirement was less if the surgery was less extensive. (3.50:4.37).

## DISCUSSION

The use of proteolytic enzymes for the reduction of post-traumatic tissue reaction has been the subject of extensive clinical and experimental study. While some very convincing results have been ob-

**TABLE IV. ANTIBIOTICS**

| | % Fissure Change | | Face Swelling (+) | | # Narcotic Doses | |
|---|---|---|---|---|---|---|
| | With antibiotic | Without antibiotic | With antibiotic | Without antibiotic | With antibiotic | Without antibiotic |
| Chymoral | 57.6 | 49.2 | 6.3 | 5.3 | 5.0 | 5.2 |
| Tandearil | 57.6 | 41.6 | 6.1 | 5.8 | 2.1 | 2.8 |

**TABLE V. ADDITIONAL PROCEDURES**

| Type I (Intranasal) | Type II (Extranasal) |
|---|---|
| Transverse Pinning | Cartilage Implant To Chin |
| Turbinectomy | Resection of Chin Protrusion |
| Polypectomy | Otoplasty |
| Pyramidectomy | Z-plasty Upper Lip Mucosa |
| Weir Procedures | |
| Cartilage Implants | |

**TABLE VII. EFFECT OF CHYMORAL AND TANDEARIL ON THE THREE PARAMETERS**

| | No. Cases | % Change in Orbital Fissure | Facial Swelling (+) | # Narcotic doses |
|---|---|---|---|---|
| Control | 10 | 57.7 | 6.9 | 4.20 |
| Treated | 50 | 49.6 | 5.8 | 3.84 |
| Chymoral | 25 | 52.5 | 5.7 | 5.12 |
| Tandearil | 25 | 46.7 | 5.9 | 2.56 |

**TABLE VI. ADDITIONAL PROCEDURES ON FACE**

| | % Fissure Change | | | | Swelling of Face (+) | | | | # Narcotic Doses | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Control | Treated | Chymoral | Tandearil | Control | Treated | Chymoral | Tandearil | Control | Treated | Chymoral | Tan. |
| Standard Rhinoplasty | 66.6 | 51.6 | 60.6 | 39.6 | 7.5 | 6.3 | 6.0 | 6.6 | 3.50 | 5.14 | 6.50 | 3.33 |
| 1 or More Additional Procedure | 55.5 | 49.3 | 51.0 | 47.7 | 6.7 | 5.7 | 5.7 | 5.8 | 4.37 | 3.63 | 4.86 | 2.45 |

tained in the laboratory,[3] the reproduction of similar beneficial results in the clinical material under rigid control has been rather difficult. An attempt was made in our study, by measuring the orbital fissure and by standardizing the narcotic dose, to minimize although, admittedly, not to abolish, some of the subjective phenomena involved in this kind of a study. It is to be impressed, however, that in clinical practice in general and in plastic surgery in particular, appearances do play an important role and the present study was deliberately kept out of the realm of the laboratory.

The present series is small compared to the Tandearil series reported previously.[1] However, it does bring out certain trends in Chymoral therapy which may be helpful in returning the patient to early normalcy after surgery. Meanwhile, the search for an ideal anti-inflammatory for postoperative trauma must continue.

## SUMMARY AND CONCLUSIONS

Sixty cases of rhinoplasty were observed postoperatively for facial edema, orbital fissure size, and narcotic requirement. Twenty-five received Chymoral and twenty-five Tandearil in specified dosage schedules and ten served as controls.

1. All the three parameters studied were worse in the control series when compared with either the Chymoral or the Tandearil series, indicating the effectiveness of the anti-inflammatory agents (Table VII).
2. Tandearil proved considerably more effective than Chymoral in reducing the postoperative tissue reactions and narcotic requirement.
3. No gastric upset was noted with Chymoral, but occurred in two cases on Tandearil.
4. The female sex showed greater facial swelling, greater change in orbital fissure and greater narcotic requirement in the control series. Tandearil was more effective in the female than in the male but Chymoral was indifferent as to sex.
5. Age of the patient had no relationship to response to either Chymoral or Tandearil therapy.

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### Acknowledgments

The authors are grateful to Drs. Richard E. Straith, James Lawson and Enrique Sabbagh, of the Straith Clinic, for permission to use their clinical material for this study.

## Relaxant Drugs in Paraplegia

(Continued from Page 331)

matic origin is discussed and attributed, in large part, to high-speed automobile accidents. Electromyographic (EMG) studies of 14 paraplegic patients given either or both of two skeletal muscle relaxant drugs (mephenesin and methocarbamol) and/or a barbiturate (secobarbital) are presented.

No evidence was found of any appreciable difference in the EMG records of these patients with the skeletal muscle relaxant drugs and with the barbiturates, nor was there any indication of selective suppression of polysynaptic over monosynaptic reflexes with any of the three drugs used. The side effects of all three drugs were comparable, the most common ones being weakness and lethargy and sleepiness. These effects would appear to be those of cerebral depression.

The opinion is expressed that the so-called skeletal muscle relaxant drugs are, in actuality, central nervous system depressants, and that these new medications are of limited value in the management of paraplegia.

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# MSMS Centennial Series: 1959, 1960

## *Construction of Headquarters Completed*

### 1959

When asked about his contributions to the Michigan State Medical Society, Doctor Saltonstall said, "Many hours and many miles and sincere effort to do my best for the Michigan State Medical Society." And his year's work as President shows he did just that.

The major event in 1959, perhaps, was the groundbreaking ceremonies for the new MSMS headquarters in East Lansing on April 1. The first shovelful of earth was turned as members of The MSMS Council and the Woman's Auxiliary observed.

* * *

THE CEREMONIES for the laying of the cornerstone were on September 27, attended by more than 150 doctors and their wives.

The Council in September voted to schedule the 1965 Centennial Session in Detroit because the first meeting had been held there.

In June it was reported that the MSMS Group Life Plan had been approved by the State Insurance Commissioner and that a total of 907 members requested coverage.

MSMS approved the establishment of a Central Cancer Registry in Detroit.

As authorized by the 1958 House of Delegates MSMS established a committee to study alcoholism.

The Medical Care Insurance Committee recommended that MSMS approve a plan to provide medical and surgical protection for people over 65 with modest and low incomes. The plan would incorporate three major proposals: 1. That the MSMS (Blue Shield) offer its contracts for the first time to persons over 65; 2. That the contract subscription rates be based on fee charges by doctors which are about 30 per cent below the average fees in Michigan; 3. That all the present services offered by Blue Shield be retained, even though the medical care is more costly for older persons. This plan was approved and put into effect for MMS.

The doctors conducted a very elaborate survey of public opinion, and came up with the M-75 proposal for medical care MMS added diagnostic services, greater x-ray benefits, more treatments and surgery which will be paid for though the patient is not confined to a hospital. MMS also raised the income level for service benefits from $5,000 to $7,500.

* * *

MICHIGAN DOCTORS, in 1959, began paying an annual registration fee to the State Board of Registration in Medicine. Following recommendations of the 1957 House of Delegates, the Legislature set the yearly levy at $5, reduced to $30 the present $50 charge made to new doctors taking their initial board examinations prior to entering practice, and eliminated the present registration of doctors with county clerks.

Twenty-two postgraduate courses designed to keep practitioners abreast of current medical developments were offered during the 1959-60 school year at the University of Michigan Medical Center.

One of the more important features of the 1959 MCI was the public showing of "Cataract Extraction," beamed from Detroit's Providence Hospital to the public through the facilities of WWJ-TV.

Jonas Salk, M.D., discoverer of the internationally

(See Page 347)

G. B. Saltonstall, M.D.
MSMS President,
1958-59

M. A. Darling, M.D.
MSMS President,
1959-60

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*Leading up to the MSMS Centennial in 1965,* The Journal *is printing a series of articles by William J. Stapleton, Jr., M.D., Detroit, who is the MSMS Historian. This series began in the September, 1963, number of* The Journal *and will continue through August, 1965.*

The Author
WILLIAM J. STAPLETON, JR.
M.D.
MSMS Historian

# Senate Vote Awaited on H.R. 665

"We hope that the legislation which finally emerges will be sound and just, and will reflect the desires of a majority of the people."

So stated Donovan F. Ward, AMA President, on the House Passage of H.R. 665.

Michigan physicians and residents are urged to write to Senators Hart and McNamara and express their views on the three-layer cake bill that cleared the House of Delegates on April 8.

Hearings are to be conducted by the Senate Finance Committee before the bill goes to the Senate floor for consideration.

* * *

THE KEY HOUSE vote as far as the King-Anderson provision was concerned was on substitution of a Republican insurance plan which included some features of Eldercare which was sponsored by the American Medical Association. The vote was 236 to 191 against the GOP substitute.

The vote on final House passage of H.R. 6675 was 313 for and 115 against.

After nearly two months of hearings behind closed doors, the House Ways and Means Committee on March 23 approved the "three-layer cake" program which included a modified version of the King-Anderson bill, a supplementary government-subsidized health insurance plan for the elderly and an extensive expansion of the federal-state Kerr-Mills Program.

The committee vote was strictly on party lines—17 Democrats for the catch-all package and eight Republicans against it.

On the passage of the House bill, Doctor Ward commented:

"The development of this bill and its passage by the House have been characterized by unrestrained haste. It is unfortunate that the American people have been denied the opportunity to learn through public hearings just how this legislation would affect their lives.

* * *

"THE PEOPLE DO NOT understand this bill, and it is doubtful that the members of the House of Representatives can have acted with a clear comprehension of how it would affect the nation's health, how it would affect the practice of medicine or whether physicians would be able to provide high-quality medical care under the restrictions and controls it would impose on them.

"The AMA is opposed to increasing taxes on wage earners to pay hospital bills for everyone over 65, regardless of their income. We are opposed to centralizing control over hospitals and doctors under a federal bureaucracy.

"We believe in helping the elderly who need help through a program, such as Eldercare, which is administered by the states, not controlled from Washington. Public opinion surveys clearly show that a majority of the American people agree with our position."

Doctor Ward continued:

* * *

"WE HOPE the Senate will proceed with caution and will conduct full and fair public hearings so that this bill can be thoroughly understood by everyone. We hope that the legislation which finally emerges will be sound and just, and will reflect the desires of a majority of the people."

Despite a tremendous flood of letters from the public in favor of the AMA's Eldercare plan for comprehensive health insurance for the elderly under Kerr-Mills, the House committee didn't take a vote on H.R. 3727 — the Herlong - Curtis Eldercare bill.

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# Hold Session On State Health Legislation

More than 100 physicians conferred in Lansing, April 24, to develop a legislative educational effort. The meeting was called by the MSMS Council to provide information about various health bills in the Michigan Legislature.

The 100 doctors also met in councilor conferences to plan follow-through work in each district.

Details about the bills were mailed April 27 to every MSMS member.

Conference leaders urged the participants to discuss their views with their legislators. The speakers explained MSMS opposition to Senate Bill 272 about Osteopathic College Authority; Senate Bill 415 on Optometry; House Bill 2200 on Psychology; Senate Bill 398 on Chiropractics; Senate Bill 63 on Podiatry; House Bill 2169 on Governmental Reorganization; Senate Bill 658 and House Bill 2899, both on Hospitals, and others.

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## Commendations

**"The Medical profession in our state is to be commended for undertaking the necessary effort (re measles vaccinations) to stimulate parents before apathy takes a permanent hold."**

**This editorial comment of the Genesee County Herald at Mt. Morris is typical of the recognition and encouragement given by the state's newspapers to MSMS during the recent Measles Campaign.**

**This same editorial and others also pointed out the challenge ahead. It stated "Nothing short of an all-out campaign is indicated."**

The special Beaumont Lecture program is studied by Beaumont Lecturer William B. Bean, M.D., second from right, at the Wayne County Medical Society Headquarters. Conferring, left to right, are Conrad R. Lam, M.D., Chairman, WCMS Lectureship-Historical Committee, Mrs. Bean, Doctor Bean and his daughter Marjorie. (Michigan Medicine Photo)

## *Beaumont Lecturer Describes Obscure Diseases at WCMS*

Rare diseases were discussed by William B. Bean, M.D., University of Iowa professor, when he recently gave the 44th Annual Beaumont Lecture of the Wayne County Medical Society.

Doctor Bean told the WCMS members April 5 that, "Often an obscure disease throws a light—sometimes obliquely—on some of the more common and troublesome diseases."

Dr. Bean discussed the Carinoid syndrome, Panchondritis, Marfan's syndrome, Munchausen's syndrome and others.

The Beaumont Historical Room at the WCMS Headquarters contains the Beaumont Lectures which began in 1922.

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## Fine Clinical Programs New On PG Sked

"The planning committee is enthusiastic about the 1965 MSMS Spring Extramural Clinics and Lectures, and especially about the four regional afternoon clinical programs. We sincerely hope the MSMS members will respond."

So states Harry A. Towsley, M.D., Chairman of the MSMS Postgraduate Education Committee.

The new elements developed over the past year by the Committee, The Council, include four full afternoon clinic programs with distinguished visiting faculties, and three late afternoon clinic programs on a smaller scale.

All physicians in the areas of Port Huron, Midland, Kalamazoo and Marquette are urged to attend the regional clinical programs.

The May calendar features:

**Port Huron, 2 p.m., May 11**

**Midland, 2 p.m., May 13**

**Kalamazoo, 2 p.m., May 20**

**Marquette, 2 p.m., May 20**

The Committee will send highly-regarded medical educators from the School of Medicine at the University of Michigan and Wayne State University to 18 Lower Peninsula communities and eight Upper Peninsula communities.

## Invite Nominees For MSMS Awards To Top Physicians

The component medical societies are invited to nominate members for possible selection as "Michigan's Outstanding Physician" or as recipients of "Certificates of Commendation."

June 1 has been set as the deadline for the nominations. Nomination forms have been sent each component society.

The selections will be presented to the 1965 House of Delegates during the MSMS Centennial Session, September 19-24. Lawrence A. Drolett, M.D., Lansing, is chairman of the House Committee on Michigan's Outstanding Award; and James D. Fryfogle, M.D., Detroit, chairman of the Committee on Certificates of Commendations.

The committees were named by J. J. Lightbody, M.D., Detroit, Speaker.

The 1964 House of Delegates took action to establish annual recognition of Michigan's Outstanding Physician. The report of the Reference Committee adopted by the Delegates provided that "the Speaker annualy appoint an ad hoc committee to make the selection from nominations submitted by component medical societies." The resolution adopted by the delegates provided that this recognition be given to a member of the profession, "who is not necessarily a family physician, nor one advanced in years. . . ." The resolution resolved also "that consideration be given to the physician's civic accomplishments as well as his professional accomplishments."

The 1961 House of Delegates, in approving the Certificates of Commendation, pointed out that the new award "may include both scientific and/or public service and may be awarded to one or more physicians annually who distingush themselves in the medical profession."

The House of Delegates has approved the recommendations each year of the Committee and has granted 14 Certificates in 3 years.

# National Health Week Set; Time Now to Plan

The AMA Board of Trustees has officially designated November 7-13 as Community Health Week for 1965.

The Council acted April 14 to approve plans for MSMS to again cooperate in the educational public relations project.

MSMS encourages all county medical societies to encourage other members of the community health team to join with them in making plans to mark this third annual observance of Community Health Week with significant local programs.

Primary objectives of this nationwide observance are to stimulate greater public awareness and appreciation of the wealth of health facilities and services which are available locally and to stress the health progress and medical advances which have been made locally through the concerted effort of all members of the community health team.

The continuing theme for the observance will be "Teaming Up for Better Health."

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# WSU to Honor McLean, Scott

Don W. McLean, M.D., Detroit, MSMS Councilor, and Gordon H. Scott, Ph.D., WSU Vice President for Medical Development, will be honored at the 97th Annual WSU Clinical Program and Alumni Reunion Banquet, May 19 in Detroit.

The clinical program will feature eight outstanding medical men. The luncheon program, compliments of Parke, Davis & Company, will feature the dean of the School of Medicine, Ernest D. Gardner, M.D.

Other features are the scholarship awards to medical students and the honoring of the Class of 1915.

Hugh W. Henderson, M.D., is President of the Medical School Alumni Association.

## Offer Aphasia Booklet

DETROIT—The Michigan Heart Association is offering a new booklet, "Aphasia and the Family." The 25-page booklet has three parts, "Understanding Aphasia," "The Family Part in the Recovery of the Aphasic Patient" and "Helping the Aphasic Patient Improve his Use of Language." Write to Michigan Heart Association, 13100 Puritan, Detroit 27.

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ANN ARBOR—The University of Michigan will hold a two-day Conference on Adolescent Medicine June 25-26 with more than 20 speakers from the U-M, Columbia University, Albert Einstein Medical School, the University of Washington, and other medical centers. Subjects will include: sexual development, endocrine disorders, athletic injuries, early marriage and pregnancy, and psychiatric problems of adolescence. The symposium will be sponsored by the U-M department of postgraduate medicine.

# Ottawa Doctors Offer Help for Mental Project

Surplus donations to the polio vaccine program are being used to help initiate an Ottawa County Mental Health Program.

The Ottawa County Medical Society is turning over $6,085.32 to start the mental health work, authorized under Public Act 54, 1964. It permits setting up the program on a community basis.

Donations received for the polio cubes given the clinics brought in $41,301.27. Expenses were reduced when a drug firm gave the county a special price for being one of the pilot areas in the oral polio program.

This resulted in a profit of $12,170.63 after expenses of $29,130.64 were taken out. Half of the surplus was turned over to the Ottawa chapter of the National Polio Foundation, or $6,085.32 to be applied in reducing bills of Ottawa County polio patients.

# *MICHIGAN STUDY GUIDEBOOK ON SMOKING RATES HIGH*

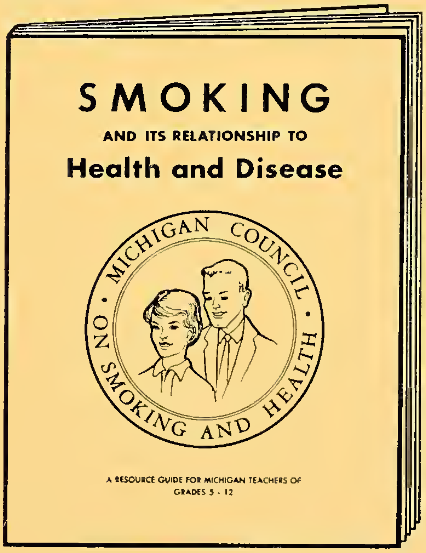
The fine 32-page Michigan textbook for children on smoking ranks as one of the very best in the nation.

The publication recently was described by Henry J. VandenBerg, Jr., M.D., Chairman of the MSMS Cancer Control Committee, at a meeting in U. S. Surgeon General Terry's office.

"It was by far the best in the nation and likely will be the model for several other states," Doctor VandenBerg reports. The booklet, "Smoking and Its Relationship to Health and Disease," is designed for use in grades 5 through 12 in both public and parochial schools. More than 25,000 have been distributed by the Michigan Health Council to school officials and health educators.

The MHC serves as the coordinating organization for the new Michigan Council on Smoking and Health, which produced the Guide. Cooperating in the new Council on Smoking are Michigan State Medical Society; Michigan Health Council; American Cancer Society, Michigan Division; American Cancer Society, Southeastern Michigan Division; Michigan Cancer Foundation; Michigan Tuberculosis and Respiratory Disease Association, and Michigan Heart Association.

Interested MSMS members may obtain a copy from MSMS, Box 152, East Lansing.



SMOKING

AND ITS RELATIONSHIP TO

Health and Disease

A RESOURCE GUIDE FOR MICHIGAN TEACHERS OF GRADES 5 - 12

# Draft to Call 91 Interns

The State Selective Service system announced recently that 91 Michigan doctors will be inducted into the armed forces in July.

All will be interns who complete their training this spring, said Col. W. J. Myers, deputy director. All will be given the opportunity to apply for a commission in lieu of being drafted, Myers said.

Wayne County will provide 41 men of the quota, Oakland 10, Kent 6, Washtenaw 4, Ingham 4, Calhoun 3, Eaton 3, Genesee 3, Jackson 2, Midland 2, Macomb 2 and Alpena, Baraga, Berrien, Branch, Chippewa, Emmet, Kalamazoo, Mackinac, Marquette, Saginaw and Shiawassee counties one each.

## *Cited as "Georges"*

The *Battle Creek Enquirer and News* selected two physicians recently to receive its unique "George Award."

Honored were Jens Henriksen, M.D., for his help to handicapped, and James W. Hubley, M.D., for work in cancer prevention. The newspaper explains that "A George, you know, is a man or woman who sees a job that needs doing in his community and does it, without fanfare and without expecting material remuneration."

## U-M Offers Summer PG Course at Bellaire

The U-M Department of Postgraduate Medicine will present a five-day program this summer at Shanty Creek Lodge, Bellaire.

"For a number of years we have hoped to offer a continuing medical education program at a popular summer recreation area," declares John M. Sheldon, M.D., head of the U-M department.

The program will begin on the morning of June 28 and conclude the afternoon of July 2.

U-M professors slated to speak include Doctors Norman F. Miller, James L. Wilson, Franklin D. Johnston, Arthur C. Curtis, Jerome W. Conn, Charles G. Child, and Raymond W. Waggoner.

**Attend Spring PG Programs Offered Across Michigan**

"The more extensive a man's knowledge of what has been done, the greater will be his power of knowing what to do."

—Benjamin Disraeli
1804-1881

## Time to Register for Keyport Trauma Day

The Committee on Trauma of the American College of Surgeons, with Ben Henig, M.D., as chairman, will hold its Keyport Trauma Day at Gaylord, July 1, 1965. Registration will be in the morning, and the meeting will be during the afternoon.

The evening speaker will be Earl J. Hill of the Consumers Power Company, on the "Accent on Good Will."

Those who desire to attend should contact Kenneth Fisher of the Otsego Ski Club for reservations.

## Hospital Week May 9-15

National Hospital Week, sponsored by the American Hospital Association, is being observed across the nation by Hospitals, May 9-15.

# '65 Show Invites Art In 6 Classes

Plans are well underway for the 5th Annual Michigan, "Doctors and Wives" Art Exhibit to be held at Cobo Hall during the MSMS Centennial, September 21-22-23.

Entries are limited to MSMS members and their wives and all work must be completely original. Each entrant is limited to four entries which may be in one class or a combination of classes.

Awards will be given in six classes:

Class I—Paintings, including oil, encaustic lacquer, polymer, etc.

Class II—Paintings, including watercolor, casein, tempera, gouache and pastel.

Class III—Sculpture, all media.

Class IV—Ceramics

Class V—Drawings and Graphic Art, including all print techniques.

Class VI—Three-dimensional design; weaving.

"Plan your art work before taking off for your summer vacation," urges Mrs. George E. McKeever, Art Show Chairman, 1767 Culver, Dearborn, 48124.

Physicians and clergymen conferred recently at Kalamazoo with Carroll A. Wise, fourth from left, of the Garrett Theological Seminar, Evanston, as the major speaker. Shown left to right at the luncheon are Charles Hubbard of the AMA Department of Medicine and Religion; Marshall MacDonald, M.D., Chairman, Medicine and Religion Committee, Kalamazoo Academy of Medicine; Rev. R. M. Trenery; Rev. Wise, Edwin Pearson, M.D., Kalamazoo Academy President; Daniel N. Finch, Bronson Methodist Hospital Administrator; and Rev. John Cermak.

*(Continued from Page 342)*

used Salk vaccine for poliomyelitis, was one of the guest speakers at the 1959 Michigan Clinical Institute.

* * *

THE MICHIGAN Association of Professions, incorporated as a non-profit organization, December 1, 1959, opened offices in Lansing. The membership in MAP an association specifically designed to serve, promote, and enhance the professions, is made up of persons engaged in the professions of architecture, dentistry, engineering, law and medicine.

A Michigan educational project, the first inservice training program ever developed for medical assistants, received praise at the second annual convention of the American Association of Medical Assistants. The local program is sponsored by the Michigan State Medical Assistants Society and the University of Michigan Extension Service.

Among the many events held in 1959 were Michigan Rural Health Conference, April 8-9; Wayne State University School of Medicine Clinic Day and Alumni Reunion, May 13; University of Michigan Medical School 7th Triennial Alumni Reunion, October 14-17; Upper Peninsula Medical Society Annual Meeting, June 19-20; County Society Executive Secretaries Conference, February 2; Genesee County Medical Society 14th Annual Cancer Day, April 22, and the Annual County Secretaries-Public Relations Seminar, January 31-February 1.

## 1960

Doctor Milton A. Darling, D.D.S., M.D., can be classified in my mind as a "Medical Leader, Statesman, and a True Follower of the Great Physician."

He was President of the Wayne County Medical Society before becoming President of the Michigan State Medical Society. He was genial and easy to approach with problems, never seemed to be in too great a hurry to answer a question and was always ready with encouragement for the younger physician.

The 1960 House of Delegates approved a five-year Presidents Program, as an all-out professional effort to culminate in September 1965 with the celebration of the 100th Anniversary of the MSMS. The goal of this campaign is to add good years to our life and to the extent of life itself.

* * *

WORK ON THE NEW MSMS headquarters in East Lansing continued during the early months of 1960 and the staff moved from 606 Townsend to 120 West Saginaw in April.

A special MSMS Workshop on the Care of the Aging was held in May for leaders in medicine, health, education, government, and civic service. The workshop had two objectives: (1) to share new information and experience in the area of aging, and (2) to explore new ways in which the medical profession can participate more actively in the Regional and Michigan Conferences on Aging. Among the recommendations were: (1) cessation of compulsory retirement policies by industry and labor, (2) sharing by the state and the community of the cost of voluntary health insurance for those in need of assistance, and (3) increasing old age assistance programs.

The Council at its January meeting earmarked $1 per member's dues for the year 1960 only to the Beaumont Memorial Foundation for the improvement and finishing of the Beaumont Memorial on Mackinac Island.

* * *

THE HOUSE OF Delegates in 1960 (1) approved a $10 per year increase in the member's dues (to $75) beginning in 1961; (2) recommended Council investigation of the possibility of forming a special loan fund to assist new doctors in establishing private practice; (3) reactivated the MSMS Cancer Control Committee, and (4) recommended that the Michigan Legislature establish a uniform healing arts registration and licensing act, and repeal the basic science law.

Michigan physicians were interested in the action of Wayne State University to adopt a new program for medical education called the 2-4-2 plan. This plan, which Wayne educators have spent five years planning and executing, involves the following: two years in the College of Liberal Arts for the completion of both liberal arts and pre-medical requirements. The next 4 years will be divided between the College of Liberal Arts and the School of Medicine. The final two years will be spent in clinical training at the School of Medicine and its affiliated hospitals.

The Michigan Health Council accepted the Michigan Cancer Foundation as a voting member. The Council now has a membership of 64 health and welfare agencies throughout the State of Michigan in approving, formulating, and developing programs of health and sociological benefit to the public.

Michigan was host for the AMA 15th annual National Conference on Rural Health in Grand Rapids.

* * *

MRS. W. G. MACKERSIE of Detroit was elected President of the Woman's Auxiliary to the AMA. She is the first lady from Michigan to gain this position.

The Woman's Auxiliary contributed $4,000 toward furnishings and equipment in a conference room at the MSMS headquarters.

Editor Wilfrid Haughey, M.D., received a scroll awarded to the Journal for having the best covers of any state medical society journal. The award was made at the State Medical Journal Advertising Bureau Conference.

Recommended Dosage
of Lomotil Liquid
to Control Diarrhea

*File: Diarrhea*

**LOMOTIL®**

| Age | INITIAL LOMOTIL LIQUID DOSAGE* |
|---|---|
| 3-6 mo. | ½ tsp. t.i.d. (3 mg.) |
| 6-12 mo. | ½ tsp. q.i.d. (4 mg.) |
| 1-2 yr. | ½ tsp. 5 times daily (5 mg.) |
| 2-5 yr. | 1 tsp. t.i.d. (6 mg.) |
| 5-8 yr. | 1 tsp. q.i.d. (8 mg.) |
| 8-12 yr. | 1 tsp. 5 times daily (10 mg.) |
| **Adult** | 2 tsp. 5 times daily (20 mg.)<br>(or 2 tablets q.i.d.) |

*Based on 4 cc. per average teaspoonful.

**Note:** After diarrhea is controlled the initial dosage can usually be reduced to meet the requirements of the individual patient.

# LOMOTIL® TABLETS/LIQUID

Each tablet and each 5 cc. of liquid contains:

diphenoxylate hydrochloride ................2.5 mg.
(Warning: May be habit forming)
atropine sulfate ..........................0.025 mg.

**Precautions**

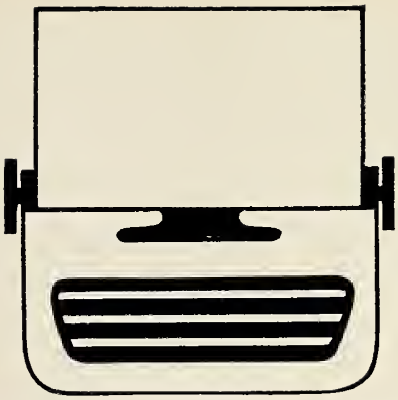
Lomotil is an exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

**Cautions and Side Effects**

Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

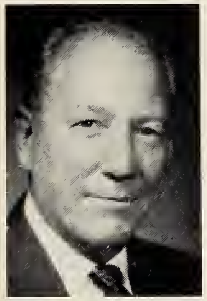
**SEARLE** *Research in the Service of Medicine*



# EDITORIAL VIEWS

## URGES ATTENDANCE

**By Donovan F. Ward, M.D., President**
**American Medical Association**



The year 1965 is a crucial year for American medicine. It is a year in which important and far-reaching events are transpiring that may have a long-lasting impact on how we practice medicine in America.

An outstanding highlight in medicine in 1965 will be the 114th annual convention of the American Medical Association June 20-24 in New York City.

Hundreds of scientific papers will be presented by the top medical scientists of our time, from foreign lands as well as our own country. Newest teaching films will be shown. Hundreds of scientists will offer exhibits in which the entire spectrum of medical progress in 1965 will be on view.

American physicians attend the AMA annual convention because they have learned through the years that nowhere else can they find out so much about new developments in medical practice; where they can learn many things that will be of inestimable value to them in their own practices.

The Council on Postgraduate Programs of the AMA has done an outstanding job in preparing the scientific programs for the 114th annual convention. This is the single most important medical scientific meeting in the world this year.

On behalf of your professional society, the American Medical Association, I urge personally that every physician in America attend the June convention.

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## A COMMENT ABOUT "APPROVED" LABS

**By Albert E. Heustis, M.D.**
**State Health Commissioner**

The statutes of Michigan use the terms *registered* and *approved* in referring to public laboratories in Michigan. The relationship between a registered and an approved laboratory is apparently not clearly understood by some Michigan physicians, especially those physicians performing medical examinations for the presence of syphilis, gonorrhea or chancroid on persons planning to make application for a marriage license.

A *registered* laboratory is defined as a public laboratory making chemical, serological and/or bacteriological laboratory tests to aid in the diagnosis and/or control of communicable diseases. Such public laboratories are required to be registered with the Michigan Department of Health. (Act No. 45—Public Acts 1931).

An *approved* laboratory is defined as a laboratory approved by the State Commissioner of Health to perform those laboratory tests necessary to assist in determining the existence or nonexistence of syphilis, gonorrhea or chancroid in persons planning to make application for a license to marry (Act 207—Public Acts 1937), or a laboratory approved by the State Department of Health to perform a standard serological test for syphilis on samples of blood taken from pregnant women (Act 106, Public Acts 1939). A list of approved laboratories is periodically provided the county clerks of Michigan by the Michigan Department of Health for premarital purposes.

The currently approved list of tests used for the serodiagnosis of syphilis includes the following tests: the VDRL test (tube and slide), the

RPCF test, the Kline test, the Kolmer test and the Mazzini test.

It will be observed that the list does *not* include the Kahn test. The Michigan Department of Health discontinued the Kahn test on February 28, 1961, because of the desirability of employing a cardiolipin antigen test, because of the difficulty in obtaining standardized Kahn antigen, and because of the lack of a sufficient number of reference laboratories. The Public Health Service Venereal Disease Laboratory has not included the Kahn test in its annual evaluation studies since 1963. Michigan laboratories were notified on June 26, 1964 that the Kahn test would no longer be recognized as a standard serologic procedure after January 1, 1965.

Thus laboratories performing the Kahn test as the *sole* serologic test for syphilis after this date could therefore neither be registered nor approved by the Michigan Department of Health.

In general, physicians may be more interested in "approved" Michigan laboratories since these laboratories are listed with the county clerks for premarital purposes. Physicians are therefore urged to be certain that premarital blood specimens are examined in laboratories listed as approved with the various county clerks.

# 29 STATES

Twenty-nine of the 50 United States have no Doctors of Medicine in their legislatures. Michigan is one of the 29. Participation in civic affairs, in community activities, and in government has long been a part of the role played by the physician in our society. We are most active in the areas of City Council and Board of Education, but we need greater participation in government at the state and national level.

Physicians are serving in the legislatures in 21 of the states. The state of Georgia, with six physicians in its House of Representatives, is the leader in the number of doctors holding state legislative office. Virginia is next with four physician-lawmakers while ten other states have two and nine states have one physician in state government. The legislative board for Puerto Rico has three doctors.

Of the total of 39 M.D.'s serving in the legislatures of 21 states, twice as many are in the House as in the Senate.

Let us hope that Michigan's men of medicine will find it possible to seek and achieve greater participation in the future.

# FACT OR FALLACY?

*Fallacy:* The AMA is ruled by a small clique of doctors.

*Fact:* The AMA practices representative democracy in its organizational structure and in development of its policies. Policies are adopted by the House of Delegates and carried out by an elected Board of Trustees. The House of Delegates is composed of physicians elected by members of state medical societies to represent them and their viewpoints in the formulation of policies. Membership in the House of Delegates, which is the policy-making, governing body of the AMA, changes from year to year. In the past three years, the House has had a turnover of 78 members—about 36 per cent. In addition to the 216-member House, between 700 and 800 physicians, representing every section of the country, serve each year on AMA committees and councils.

## *The FDA—Deteriorated?*

"The new law gave the Food and Drug Administration authority over the efficacy of drugs in addition to its original assignment, the safety of drugs. This is a responsibility that FDA was not prepared to assume. In a system of free enterprise, this responsibility belongs to the medical profession alone and not to an agency of the government. Under this new assignment, the FDA has wavered, procrastinated and quaked with indecision on rulings which often they are unqualified to make, owing to the multifaceted areas of medical science and medical practice involved.

"In addition, the volume of work has become so enormous that the staff has become inundated by its size and complexity. Time lags in getting information from the FDA have appallingly increased.

"The image of the FDA has deteriorated in the eyes of the pharmaceutical industry with which it is importuned to do its most vital and significant work."—John C. Krantz, Jr., Ph.D., in *Military Medicine*, 130:1, (Jan.) 1965.

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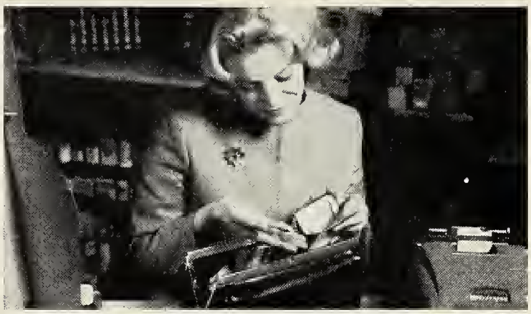

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# OUR STATE SOCIETY

## Urge PKU Test

The Council of the Michigan State Medical Society and the Michigan Department of Health join in urging each physician in the state to see that every baby delivered by him has a Guthrie PKU test for the presence of phenylalanine in the blood.

# SINAI TO ORIGINATE TV AT CENTENNIAL

Sinai Hospital of Detroit has been selected as the host hospital for daily closed circuit color programs during the MSMS Centennial Session, September 19-24.

The clinical telecasts will be viewed by physicians attending the scientific sessions in Cobo Hall in Detroit, September 21-22-23.

The Medical Television Unit of Smith Kline & French Laboratories will produce the programs.

Donald H. Kaump, M.D., TV Program Chairman, has appointed Sidney D. Kobernick, M.D., as representative of Siani Hospital, to the Committee. Other members of the Committee are: Muir Clapper, M.D., Robert C. Douglass, M.D., Richard D. Judge, M.D., Eugene A. Osius, M.D., Herbert J. Robb, M.D., John W. Sigler, M.D., and Harry A. Towsley, M.D.

New this year at the Centennial Session will be scientific programs Tuesday afternoon. An indepth closed circuit television program will be from 4:00 to 5:30. Three subjects will be telecast on Wednesday from 10:30 to 12:30, and two subjects on Thursday at the same time.

## PLANNING CENTENNIAL SESSION

The Centennial Session Program Planning Committee and representatives of MSMS Sections are shown at work at the MSMS headquarters selecting topics and speakers for the scientific portions of the Centennial week, September 19-24. This year, the scientific program will begin on Tuesday noon, September 21 and continue through Friday. Further details will follow in future issues of Michigan Medicine. In the photo at left, are (left to right), Oscar W. Miller, M.D., Detroit; Irwin C. Sweet, M.D., Gladwin; Wm. D. Cheney, M.D., Lansing; Charles J. Tupper, M.D., Ann Arbor; Kenneth H. Johnson, M.D., Lansing, and Harry A. Towsley, M.D., Program Committee Chairman. In photo at the right are (left to right), Miss Helen A. Schulte, MSMS Staff Assistant for the Committee; David Kahn, M.D., Lansing; George H. Lowrey, M.D., Ann Arbor; Clayton K. Stroup, M.D., Flint; Fred C. Brace, M.D., Grand Rapids; John D. Snider, M.D., Grand Rapids, and Murray S. Mahlin, M.D., Detroit. In the foreground is Chairman Towsley, Ann Arbor.

**SAMUEL R. SHERMAN, M.D.**

# TELLS MSMS CONFERENCE ABOUT CRITICISMS FACING MEDICINE

*(Two other articles about the MSMS Officers Conference appeared in the April issue of Michigan Medicine.)*

"If the role of medicine in society is to be one which physicians of the 21st century will be proud to proclaim, we shall have to review our experiences of the past, rigorously and objectively examine the present, and truly plan for a future in which greater complexities and more difficult decisions will have to be made."

That challenge was presented by the Awards Luncheon speaker at the 1965 MSMS Officers Conference in Grand Rapids. Speaking to the 150 officers of the county medical societies and MSMS was Samuel R. Sherman, M.D., of San Francisco. Doctor Sherman, a Past-President of the California Medical Association, is Chairman of the CMA Committee to Study the Role of Medicine in Society.

* * *

IN HIS discussion of medicine's relationships with society, Doctor Sherman also discussed the problems of communication and understanding within the medical profession. He asked, "How can organized medicine speak in a concerted and unified fashion for the profession, if within the matrix of medicine there exist strains of differences which threaten the cohesiveness of medicine and precludes consensus?"

Doctor Sherman suggested that "first we must reach an understanding among ourselves, between segments of the medical profession itself and between the goals and desires of medical education, scientific research and the physician in what we have historically termed 'Private Practice.'"

The CMA Committee to Study the Role of Medicine in Society has conducted interviews with representatives of many segments of the society, and has reviewed considerable literature. Doctor Sherman told the Michigan physicians that "our search has opened new vistas and horizons for exploration, has given us insights which we never had before or did not fully exploit, and has provided us with opportunities to identify ourselves—both singly and collectively—with the problems of society."

In making its progress report to the California Medical Association House of Delegates, the Committee presented some specific suggestions and summed up its generalized findings by making five recommendations:

THE FIVE RECOMMENDATIONS, Doctor Sherman said, were:

1. The medical profession should increase its efforts to identify itself with the total medical care problems of society. It should study—and try to understand—these problems. It should assume leadership in the formulation, with others, of solutions to these problems. It should offer proposals which recognize the valid interest of both the public and the profession. It should inform the public more fully of its existing and projected studies and proposals, and of its increasing concern with problems of mutual interest.

2. The medical profession should present creative, constructive, and positive programs, and should modify its position on matters of public policy, wherever such actions are in the interest of improvement of health.

3. The medical profession should seek to arrive at a closer consensus regarding the nature of the proposals it presents to the public. It should strive to unify its members, to gather to its fold all physicians and voluntary health insurance mechanisms whose objectives are improved patient care, to encourage and support experimental methods for lowering costs, and to maintain and improve the quality of medical care rendered to the public.

4. The medical profession should recognize the

*(Continued on Next Page, Col. 1)*

## California Study Finds 29 Charges To Correct

Michigan physicians attending the MSMS Officers Conference in Grand Rapids for county and state society leaders heard a speaker list 29 types of criticisms relating to medicine's role in society. Presenting the list for discussion and consideration. Samuel R. Sherman, M.D., of California, explained that, "in a number of instances, the assertions relate to the perceptions of the profession as a whole rather than to any specific segment of it or any particular geographic area." The list of 29 is quoted from his speech:

1. The medical profession, by and large, is unaware of or indifferent to the vast social, political, and economic alterations of our society and seeks to rationalize these changes.

2. Medicine and medical education have failed to recognize that they are integral, interrelated, and inter-dependent

*(Continued on Page 357)*

*(Continued from Preceding Page)*

causes, technologic advances, and reliance on team efforts, for what appears to be a growing detachment from the patient, and should try to revitalize the meaning of the physician-patient relationship.

5. The physician should be inculcated with the concepts of his individual and social roles and responsibilities during his period of professional training. This must permeate both undergraduate training and the indoctrination of post-doctoral house staff training. All too often the specialty training of the resident or intern emphasizes techniques and procedures with little effort to develop real concern for the patient.

In his references to the problems faced by medicine, Doctor Sherman said the solutions may not be easy to achieve. He added, "Indeed we may even find it difficult to communicate to segments of the public the nature of our philosophy and orientation on behalf of the health of patients we serve because of the discrepant values and traditions which exist not only in our society but within our profession itself."

* * *

"THIS IS ALL the more reason," he contended that, "why we must concern ourselves with learnings and teachings of the behavioral and social sciences so that we may truly participate in what a distinguished cultural anthropologist terms a 'shared culture' rather than thinking of ourselves, or having the public perceive us, as an elite body interested in the human and social problems of society—concerned only with economic goals and impersonal scientific relationships."

Doctor Sherman said he personally had made several observations about the medicine-in-society study. Doctor Sherman said, "None of our communications will even be effective unless the nature of our discourse is conducted in a setting in which we speak to and with the public in a common language of understanding." He also said, "We must relate ourselves to the interests and anxieties of society, rather than create the impression by deed or word that our physician-patient relationship is an impersonal one, rather than a human-to-human one."

He also offered the personal suggestion that "We must present timely solutions which recognize the valid interests of society and medicine of which it is an integral part."

## IT'S UNETHICAL

The American Medical Association has notified American Pharmaceutical Association that the AMA Judicial Council had adopted the following opinion:

"It is unethical for physicians to use prescription blanks with the name of a pharmacy printed thereon."

In an accompanying letter, William J. McAulliffe, Jr., Director, AMA Department of Medical Ethics, asks APhA for "assistance in eliminating this practice."

## RECEIVE RECOGNITION

Congratulations were exchanged by three honorees at the Officers Conference following the Awards Luncheon at the Pantlind Hotel. Honored as presidents of national medical organizations, left to right, are Brock E. Brush, M.D., Detroit, President, American Geriatrics Society; D. Emerick Szilagyi, M.D., Detroit, President, International Cardiovascular Society, and Harold F. Falls, M.D., Ann Arbor, President, National Medical Foundation for Eye Care. The fourth MSMS honoree, H. A. Towsley, M.D., Ann Arbor, President, American Academy of Pediatrics, was unable to be present to receive his citation. Doctor Towsley received his award April 13 at his county society meeting.

## EXPLORE NEW PR IDEAS

Looking at materials at the MSMS Public Relations Idea Display are two special guests at the Officers Conference. They are left to right, Mrs. Henry Scovill, Ypsilanti, President-Elect of the Woman's Auxiliary to MSMS, and Miss Phyllis Marguardt, Kalamazoo, President, Michigan State Medical Assistants Society.

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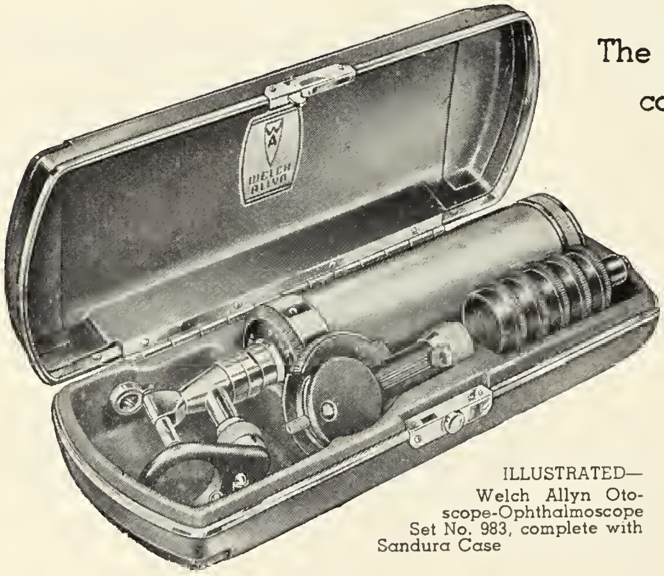

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## *California Study*

*(Continued from Page 354)*

parts of society and that they must conduct themselves accordingly.

3. Major medical organizations tend to move slowly in social and economic alterations and are not responsive to public demands for change.

4. Medicine chooses to remain aloof and not to involve itself in many problem areas which are of direct concern to the welfare of patients and, therefore, to the public.

5. Medicine tends to approach human, social problems from a pedestal without attempting humanitarian approaches which are necessary for their proper solution.

6. Medical educators, similarly, are apt to ignore the need to impart at the student level information regarding the social and economic aspects of medical care which are equally important to the welfare of the patient, the physician, and the public.

7. Medicine tends to rely on political maneuvering rather than attempting to explore by public discussion a realistic consideration of its views on fundamental problems.

8. Individual physicians are rarely educated in the social, economic, and anthropological social sciences, and remain indifferent to these matters. Thus, they are poorly prepared to exert leadership in these fields.

9. In the formulation of its public policy, medicine has not convinced the public that it *does* believe that everyone should have access to medical care when it is needed. Medicine questions the establishment by Federal law of medical care as a guaranteed "right," but does not at the same time make effective public policy statements and communications of its positive beliefs.

10. Medicine has not been successful in leading the public to accept its own concept of government's proper role in the provision of medical care.

11. Medicine does not adequately support its Blue Shield plans. It needs to make more effective use of the "service principle."

12. Medicine has not yet developed positive, workable alternatives to the financing of medical care through the Social Security mechanism.

13. Medicine has a negative attitude toward proposals for social changes; it is "opposed to everything."

14. Medicine traditionally aligns itself with those organizations which are reactionary and opposed to social progress.

15. Physicians' incomes are too high in relation to those of other professions.

16. The medical profession is not interested in controlling medical care costs. It lacks interest in promoting preventive, rehabilitative, and comprehensive medical services.

17. Medicine protects its own members even when their behavior indicates the advisability of censure or disciplinary action.

18. Medicine is divided in the acceptance of closed panels, and tends to exclude or ignore physicians who work in them.

19. Physicians are providing impersonal medical care; they are unwilling to devote sufficient time to understand the patient or to appreciate his total problem.

20. Physicians are indifferent to the total environment of the patients they serve.

21. The medical profession is fragmented by overspecialization. Specialists treat the patient impersonally, shuffle him about, and often overcharge.

22. Many physicians work "for those who pay them"—insurance companies, lawyers, etc., rather than recognizing their primary obligation to the patient.

23. California needs to educate and produce more physicians to supply its existing needs. It is not fulfilling its responsibility in medical education and continues to be a "debtor" State in the education of physicians.

24. Although there appear to be enough physicians, they are poorly distributed in some ethnic and low income groups.

25. Physicians have inadequately provided broad medical services to certain distressed or impoverished areas and populations.

26. The medical profession does not do enough to assist capable students in the financial problems of obtaining a medical education.

27. The medical profession is lax in providing and requiring postgraduate and continuing education of its members.

28. Many physicians consider that those in medical teaching and research activities are no longer "doctors," and do not recognize that concern for the patient is the prime function of all physicians, common to all levels of patient care.

29. Physicians, as members of the health team, are arrogant and fail to give proper recognition, responsibility, and appreciation to the ancillary services.

## CONFERENCE LEADERS

Three of the key leaders at the MSMS Officers Conference were, left to right, R. W. Teed, M.D., Ann Arbor, Chairman, MSMS Public Relations Committee; R. A. Frary, M.D., Monroe, Chairman of the County Secretaries group, and C. Allen Payne, M.D., Grand Rapids, who spoke in the afternoon as Chairman of the Centennial Session Program Committee.

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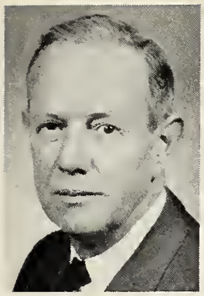

HARRIS

REVENO

# Blue Cross Board Re-Elects Physicians

Two representatives of the medical profession were re-elected to the Board of Trustees of the Michigan Blue Cross at the recent annual meeting. They are Herbert W. Harris, M.D., Lansing, and William S. Reveno, M.D., Detroit.

Seventeen were elected to the board.

Re-elected as public members were: Milton J. Drake, executive vice president of the Detroit Bank and Trust Co.; Edward P. Fisher, president of the Bank of Lenawee County, Adrian; Larry Gettlinger, administrative assistant to the president of the United Automobile Workers, Detroit; John W. Paynter, financial vice president of the J. L. Hudson Co., Detroit; W. Albert Schaller, publisher of the Petoskey News-Review; Robert E. Smith, a Fowlerville farmer, and John P. Sullivan, general assistant treasurer of the General Motors Corporation. Elected as a new public representative was Howard C. Grimes, Lansing, president of J. W. Knapp Co.

Chosen to represent hospitals were C. Tiffany Loftus, administrator of Mercy Hospital in Benton Harbor; John E. Rasmussen, director of Hillsdale Community Health Center; George E. Cartmill, director of Harper Hospital, Detroit; Owen R. Pinkerman, director of William Beaumont Hospital, Royal Oak; Walter R. Doud, administrator of St. Luke's Hospital, Saginaw; Lajoie R. Faust, administrator of Port Huron, Hospital, and Frank Drazkowski, Jr., administrator of Grand View Hospital, Iron Mountain.

## CHA 50 Years Old

More than 1,500 Catholic hospitals, nursing homes, schools of nursing and affiliated organizations throughout the U. S. and Canada are observing the 50th year of the Catholic Hospital Association.

Highlight of the year-long observance, devoted to the theme of "The Past . . . a Prologue," will be the Golden Jubilee Convention in St. Louis from June 8 through 11.

# ANCILLARY SECTION

## EXAMINE 200 YOUTHS IN METRO SAMPLE

The Public Health Service's Health Examination Survey spent four weeks in the Detroit metropolitan area to examine a sample of the child population (ages 6 through 11 years). The examinations were given over a period beginning March 29.

The survey is part of a nationwide sampling study of children.

The children were chosen by a scientific sampling process from the 6-through-11-year population throughout Detroit City, Wayne, Macomb and Oakland county areas. Approximately 200 children were selected in the sample.

Examinations were given in the Health Survey's mobile Examination Center.

The purpose of the survey was to collect on a uniform basis statistical information on various aspects of children's health and to obtain data on certain physical and physiological measurements of these children, relating to growth and development.

## Orthopaedic Society Plans June Conference

The Annual Summer Meeting of the Michigan Orthopaedic Society will be held at Hidden Valley Lodge, Gaylord, Thursday, June 10, through Saturday June 12.

Scientific program meetings will be held Friday and Saturday.

The scientific program has been arranged by William Smith, M.D., Professor of Orthopaedic Surgery, University Hospital, Ann Arbor, and his staff.

Guests are requested to make their reservations at Hidden Valley Lodge directly through the General Manager, Hidden Valley Lodge, Gaylord.

## Handbook Is Available On Research Bequests

AMA-ERF has just issued a concise handbook on making bequests to medical research. This handbook brings a semblence of order to a field which is confusing because of rapid changes, new findings and the sheer volume of research in universities, hospitals and medical centers.

The handbook warns of obsolescence in bequests. Money left today to fight a specific disease may well fall into disuse tomorrow because of the march of medical science, the AMA-ERF points out. The booklet declares "There is a way to avoid the danger of making research bequests that could become outmoded: name a general category of diseases, with preference given to the disease in which the donor is interested. Generalizing permits the gift to be applied to related diseases if necessary."

A copy of "A Handbook for Making Bequests to Medical Research," is available from AMA-ERF, 535 N. Dearborn St., Chicago, Illinois 60610.

## WSU MEDICAL SCHOOL APPOINTS REPRESENTATIVES

Twenty-one doctors have been named regional representatives for Wayne State University's School of Medicine Alumni Association.

Along with other representatives, all graduates of the School of Medicine, have been invited to participate in policy forming sessions in Detroit, May 19.

The occasion for the meeting will be a Clinic Day, which medical alumni sponsor at the school each year as one means of keeping University graduates up-dated on latest medical advances.

The doctors appointed as regional representatives are:

Frank H. Clark, M.D., '28, Cleveland; Henry Cook, M.D., '09, Flint; Kenneth L. Crawford, M.D., '29, Kalamazoo; Alexander B. Gwinn, M.D., '30, Hastings; Louis F. Hayes, M.D., '47, Gaylord; Henry J. Klos, M.D., '44, St. Joseph; Donald A. Koch, M.D., '35, Port Huron; Lester C. Kraft, M.D., '33, Leslie; Edward Kupka, M.D., '28, Berkeley, California; Warren Lambert, M.D., '32, Marquette; Walter E. Larson, M.D., '31, Cheboygan; Edgar C. Long, M.D., '31, Monroe; Arther A. McNabb, M.D., '16, Watervliet; John G. Milliken, M.D., '44, Traverse City; Benjamin T. Montgomery, M.D., '24, Sault Ste. Marie; Albert P. Murphy, M.D., '35, Saginaw; John D. Pool, M.D., '51, Kalamazoo; James E. Spens, M.D., '43, Alpena; E. Clinton Texter, M.D., '46, Kenilworth, Illinois; Kenneth W. Toothaker, M.D., '32, Lansing; William C. Wyte, M.D., '43, Mt. Clemens.

## DISCUSS IMMUNIZATION

Educational programs about measles and immunization were presented by the Michigan Association of the Professions over both WJIM-TV in Lansing and WJBK-TV in Detroit during the MSMS measles campaign. Shown here at the Lansing program, left to right, are Frederick J. Margolis, M.D., Kalamazoo, Vice-Chairman, MSMS Child Welfare Committee; E. S. Barclay, M.D., Director, biological production of Merck Sharpe and Dohme Laboratories, Westpoint, Pa.; MSMS Executive Director Hugh Brenneman; Mrs. Barbara C. Bernheim, Division of Biologic Standards, National Institutes of Health, Bethesda, Md.; and Harry M. Meyer, Jr., also with the division Biologic Standards.

### SUNDAY, JUNE 20, 1965

### 7th Annual AMA-ASHA Preconvention Session on School Health in New York City

Outstanding speakers from medicine, science, and education on various aspects of school health programs.

For additional information, write to:

Department of Community Health
and Health Education

**AMERICAN MEDICAL ASSOCIATION**

535 North Dearborn Street
Chicago, Illinois 60610

### AMA MEETINGS

1965—Annual Meeting: New York, June 20-24
Clinical Meeting: Philadelphia, Nov. 28-Dec. 1

1966—Annual Meeting: Chicago, June 26-30
Clinical Meeting: Las Vegas, Nevada, Nov. 27-Dec. 3

1967—Annual Meeting: Atlantic City, June 18-22

KEEP MICHIGAN BEAUTIFUL

## Meet "Ozzie the Otter"

Physicians serve as boosters of Michigan—and are interested in the new "Keep Michigan Beautiful" campaign of the Michigan State Chamber of Commerce. Governor Romney has designated the state chamber as the coordinating agency for the state's share in the "Keep America Beautiful" effort.

Officials of the Michigan State Chamber of Commerce appeal to MSMS members to help with their three-point formula—Public Education, Adequate Trash Collections, and Proper Enforcement. Helping to focus attention on the 1965 spring push is "Ozzie the Otter."

* * *

## Ancillary Briefs:

The Third Annual Symposium of Muscle Disease will be held at the Wayne County Medical Society, May 26, between 9 a.m. and 5 p.m. This meeting is sponsored by the Department of Neurology of Wayne State University School of Medicine and the Muscular Dystrophy Association of America, Wayne County Chapter. Inquiries should be addressed to M. K. Newman, M.D., Chairman of the Symposium, 16861 Wyoming Avenue, Detroit 21.

Michigan high school students are enrolled for a summer workshop at University of Akron to learn more about careers in medicine, the program is part of the nation-wide "Scientists of tomorrow" project. Akron now reports seven Michigan registrations for June 27-July 10.

## *Dow Corning Helps Cardiac Surgeons*

A new artificial heart valve and a new coronary artery perfusion cannula were introduced recently at the American Association for Thoracic Surgery meeting in New Orleans by Dow Corning Corporation, of Midland. Both the heart valve and cannula were developed and clinically evaluated in cooperation with university heart specialists.

The new valve's "Butterfly-wing" opening concept and clot-inhibiting surface coating constitute its two most significant contributions to prosthetic valvular development. The compact, lightweight heart valve is intended to minimize difficulties encountered with earlier prosthetic valves.

The coronary perfusion cannula represents a new materials and design approach to cannulae presently in use. Made entirely of Silastic medical-grade silicone elastomer, the cannula's complete flexibility gives the surgeon an unobstructed operative field and permits continuous coronary perfusion during open heart procedures. A conical-shaped silicone ball design at the artery placement end of the cannula minimizes the hazards frequently encountered with the insertion of cannulae into the coronary arteries.

## Cites Coordination in Michigan

Michigan schools and other medical organizations which offer continuing psychiatric education to primary physicians have created a Council on Continuing Psychiatric Education to coordinate their efforts. Two psychiatrists serve as Council President and Vice President, Paul Lowinger, M.D., and David B. Ruskin, M.D., respectively; a general practitioner, Francis P. Rhoades, M.D., serves as Secretary.

Other states and communities in the country are studying this plan with regard to the suitability of similar arrangements in their own geographic areas. Rapidly proliferating education programs have produced many courses in some areas, and fears have arisen that teaching groups will compete destructively for physician-participants or will duplicate efforts in some regions while leaving other regions inadequately covered.

The Michigan Council seeks to avoid these problems and to allay the apprehensions. Initial reaction in Michigan to the Council has been favorable.

—*Psychiatry and Medical Practice Bulletin*
Vol. 3, No. 1, 1965

## DR. WARD GETS ROYAL WELCOME

Donovan F. Ward, M.D., of Dubuque, Iowa, President of the American Medical Association, was greeted with a red carpet and a boutonniere at the Kent Country Airport, Grand Rapids, when he arrived to speak before the Congress of Professions. Placing a white carnation on Doctor Ward's coat is John M. McKay, chairman of the Mayor's Welcoming Committee. Left to right are William A. Hyland, M.D., Chairman MSMS Delegation to the AMA, Mrs. Ward, Robert D. Elsner, Doctor Ward, Ralph T. Wills, Edward J. Brunette, McKay and Noel K. Black.

## *Mediscene*

May 19—Wayne State University Alumni Day, Detroit

May 20 and 21—Clinic Days of Children's Hospital of Michigan, Wayne County Medical Society, Detroit

June 10-12—Michigan Orthopaedic Society, Summer Meeting, Hidden Valley, Gaylord

June 11-12—Upper Peninsula Medical Society Annual Meeting, Marquette

July 1—Annual Claude Keyport Trauma Day, Hidden Valley, Gaylord

July 30-31—Coller Penberthy Clinic, Traverse City

September 16-19—American Medical Writers Association, Detroit

September 19-24—MSMS Centennial Session, Cobo Hall and Sheraton Cadillac Hotel, Detroit

September 21-23—Woman's Auxillary to MSMS, Pick-Fort Shelby, Detroit

September 22-23—Michigan State Medical Assistants, Statler-Hilton, Detroit

September 23—Michigan Health Council Annual Convention, Cobo Hall, Detroit

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**Contraindications:** Hypersensitivity and most cases of severe renal or hepatic disease.
**Precautions:** Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
**Side Effects:** Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
**Average Dosage:** One tablet (100 mg.) daily with breakfast.
**Availability:** Tablets of 100 mg. in bottles of 100 and 1000.
For full details, see the complete prescribing information.

*Swartz, C., et al.: Circulation 28:1042, 1963.

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# AAMC DETAILS LIBRARY NEEDS

The Association of American Medical Colleges reports that for a number of years concern has been expressed over the medical library needs for expansion, renovation, and improved services.

The AAMC points out that medical school libraries have been unable to develop the expanded facilities and technology required to keep pace with the flood of new knowledge and information emanating from vastly increased research expenditures in the health sciences.

A survey by AAMC this year obtained estimates of library resource needs which could not be met from planned school budgets for 1965-70. Additional space needs reported by 79 medical schools indicated a total need of over 2.5 million square feet, or an average per school need of 32,000 square feet, essentially the same need as estimated in 1963.

Information from the recent questionnaires indicated a total need of over 1.3 million volumes, or an average school need of 18,000 additional volumes and periodicals.

In addition to their needs for additional space and volumes, the schools reported on their needs for support for cataloguing, binding, and other instructional media or equipment. The average per school need for these other library resources is $132,000.

The AAMC concludes that the average medical school library would have to expend over $1 million above expected budget allotments in the next five years to meet their library needs as currently estimated. This estimate does not include the additional costs of staffing, equipping and maintaining expanded facilities for the needed increases in volume holdings.

# Academy of Pediatrics Opposed to Smoking

The American Academy of Pediatrics has issued a statement opposing the smoking of cigarettes and urges its 8,500 members to "join in every effort to discourage acquisition of the habit of cigarette smoking during childhood and adolescence."

The statement, prepared by the Section Committee on Diseases of the Chest, urges pediatricians as part of their preventive medical care to raise the question of cigarette smoking with older children, adolescents and their parents. The statement said, "Because of the strong bond of friendship usually present between the pediatrician and the parents and children in the families he serves, his counsel and advice might be far more readily accepted than that of any other individual."

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# STATE HOSPITAL PLANNING GROUP ORGANIZES

Hira E. Branch, M.D., Flint, representing the Michigan State Medical Society, is a member of the board of directors of the new Hospital Research and Educational Reserve of Michigan.

Walter C. Averill, Jr., Saginaw businessman, is president of this new non-profit corporation, and will preside over the 14-member board of directors.

* * *

"THE PRIMARY PURPOSE of the new organization is to promote, create, develop and guide a coordinated system of local community or area health facilities planning councils throughout the state," Mr. Averill said.

The goal of the Reserve, he said, is statewide development of all necessary health facilities and services with the greatest possible economy consistent with a recognized and accepted standard of quality.

"Health facilities planning must encompass not only our general short-term hospitals operated under private aegis, but also nursing homes, long-term care facilities, rehabilitation centers, mental health facilities, facilities for the education and training of medical and paramedical personnel and out-of-hospital programs and services," Mr. Averill said.

* * *

THE RESERVE has established a health facilities planning council office in Lansing, with Harry J. Parke serving as associate director at the head of the organization's staff. Mr. Parke has 17 years of experience in the health field in Michigan.

The new organization consists of 34 of Michigan's civic and industrial leaders who have teamed up with voluntary health professions.

---

## *Chamberlain Survey Cool to Johnson Ideas*

Lansing area residents showed "little enthusiasm for the Great Society," according to results of a survey conducted in March by Sixth District Representative Charles E. Chamberlain, of Lansing.

Representative Chamberlain said he was surprised by "hundreds of write-in-preferences" for the Eldercare plan of medical care for the elderly being pushed by the American Medical Association as an alternative to the administration's medicare plan under social security. He said the Eldercare was not mentioned on the questionnaire because it was not proposed until after the questionnaires were printed.

Only 23 per cent of the respondents favored Medicare.

Materials for the Medical Socio-Economic Section of Michigan Medicine are provided by Richard M. Campau, MSMS Research Director.

## '64 Survey Shows Increase in Benefits

A survey conducted by the Health Insurance Institute reveals that new group health insurance programs provided by insurance companies pay an average of 83.3 per cent of hospital daily service charges. The survey involved 80,909 workers and their dependents.

The survey found that the average daily hospital room-and-board benefit for semi-private (two-bed) accommodations came to $17 a day. This benefit represents $3.40 a day less than the national average of $20.40 for hospital daily service charges which was reported by the American Hospital Association.

Daily service charges as defined by the AHA include room accommodations, food service, routine nursing care and minor medical and surgical supplies, the Institute said. Excluded are ancillary services such as operating room, X-ray, laboratory or special drugs and supplies for which benefits are provided under insurance company policies under miscellaneous hospital expense coverage.

The Institute said that its 1964 sample showed a general increase in benefit levels for hospital room-and-board charges over its study of the year before.

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# Survey Describes MD Daily Schedule

In a recent poll undertaken by *Medical Tribune* more than 1,200 physicians gave a detailed account of their daily working schedules. As might be expected, type of practice determines the pattern of working hours. Here are some comparisons.

**Least time in office:** surgeons. Nearly half say they devote only two to four hours daily to patient care in the office.

**Most time in the office:** psychiatrists. More than three-fourths checked "over six hours daily."

**Least time in hospital:** dermatologists. About 85 per cent spend less than one hour daily at hospital.

**Most time in hospital:** surgeons (excluding those specialists who work only or almost entirely in hospitals). Almost two-thirds estimate their daily hospital time as over three hours.

**Most time on house calls:** general practitioners. Half spend five hours or more on home visits in an average week; about 16 per cent specify "over 10" hours weekly.

**Least time on house calls:** radiologists. All checked "less than five hours a week," as did 90 per cent or more of psychiatrists, dermatologists, obstetricians, and surgeons.

* * *

In response to other questions, participants indicate that:

**Ward rounds,** teaching, or clinics take up less than five hours a week for the great majority (74 per cent). Locale as well as type of practice has proved a factor—the percentage of those who reported over five hours is higher among urban than among suburban or rural M.D.s and is higher among psychiatrists, pediatricians, and internists than among other practitioners.

**Continuing education:** About one-tenth of all participants reported they spend over 10 hours in an average week attending professional meetings and reading medical journals. The rest divide nearly 50-50 in reporting less than five hours or five to 10 hours.

**Office hours:** One-third say their offices are open in the evenings.

## Offer MD-Nursing Proceedings

Copies of the Proceedings for the First National Conference of Professional Nurses and Physicians entitled "Medical and Nursing Practice in a Changing World" are available ($1.50 each) from the Department of Nursing, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

What does the association of

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mean to doctors . . . hospitals . . . researchers?

Sanborn Company recently became a division of the Hewlett-Packard Company whose headquarters are in Palo Alto, California. Hewlett-Packard, now in its 25th year, has become one of the world's leading manufacturers of electronic test instruments for government, industry, and research, with plants and sales/service facilities throughout the world. It is still directed by founders Bill Hewlett and Dave Packard and enjoys the widespread respect which their integrity and ingenuity have earned.

**SANBORN will now be known as**
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Sanborn will continue to maintain engineering, manufacturing, sales, and service headquarters in Waltham, Massachusetts. The same intimate knowledge of the instrumentation requirements of the medical profession will continue to guide the management of SANBORN as an H-P Division.

In addition to all that the name SANBORN has meant to doctors over the past 48 years, this new association of SANBORN/HEWLETT-PACKARD means an even stronger organization standing behind every Sanborn instrument and system — stronger in service, facilities, technical knowledge and ability, and in desire to contribute to medical science. Sanborn Division, Hewlett-Packard Company, 175 Wyman Street, Waltham, Mass.

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# Seek to Eliminate Duplicate Payments

*(Note: This presentation is based upon information recently made available by the Health Insurance Council.)*

For several years, the health insurance industry has experimented with different anti-duplication provisions so that an insured person cannot profit from his own illness.

None has produced desired over-all results, if for no other reason than the confusion caused by the lack of uniformity in the various approaches employed. All sought the same objectives, but the absence of uniformity offered more in terms of frustration than accomplishment.

Finally, as a result of years of study and experimentation, the health insurance business has given its indorsement to a Group Model Anti-Duplication Provision with which the companies are now experimenting.

* * *

THIS "MODEL" provision is based on two guiding principles.

1. Employees and employers will accept non-duplication provided it permits recovery by the insured of all covered medical expenses.

2. In order to be effective, claim settlement has to be simple and easily understandable to employers and claimants.

* * *

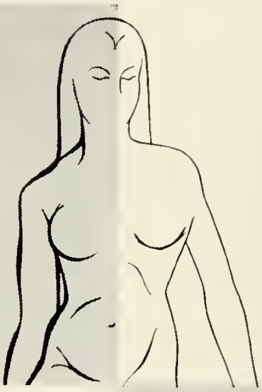
IT IS ALSO important to note that the "Model" provision was drafted in a form which makes it adaptable to basic plans (i.e., hospital, surgical and medical expense) as well as Major Medical. Briefly, the "Model" Industry provision works as follows:

1. It is a firmly established principle that when a claimant is insured under two or more plans he should be permitted to recover, in total, the amount of the reasonable and customary charges for necessary items of medical expense that are covered in whole or in part under any one of the plans before either plan reduces its benefit payment. Such expenses are referred to as "Allowable Expenses."

2. Whenever one plan does not contain a non-duplication provision, that plan must pay its benefits before the plan which does have a non-duplication clause.

3. When two or more plans contain non-duplication clauses the following "Order of Benefit Determination" establishes the sequence of payment:

A. the plan covering the patient as an employee



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pays before the plan covering the patient as a dependent.

B. the plan covering the patient as a dependent of a male person pays before the plan covering the patient as a dependent of a female person.

C. where the order of payment cannot be determined in accordance with these rules, the first plan to make payment will be the one that has covered the insured for the longer period of time.

4. The plan that pays first calculates benefits exactly as though duplicate coverage did not exist.

5. The second plan to make payment will therefore reimburse the claimant for all Allowable Expenses not covered by the other carrier provided this amount does not exceed the benefits payable under the plan in the absence of duplicate coverage.

6. Benefit credit—that amount of money which is "saved" through application of a non-duplication provision on a given claim—accrues for a subsequent period, generally one year, as a credit to be applied against future claims.

* * *

THE NET EFFECT of this arrangement is that the claimant is either reimbursed for 100 per cent of his Allowable Expenses or receives the full benefits payable under both plans that would have been allowed if neither plan continued non-duplication provisions.

## HOSPITAL COVERAGE CONTINUES TO CLIMB

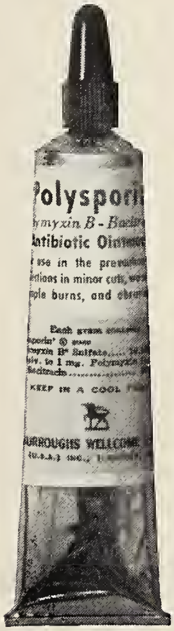
Group hospital-expense insurance, provided by insurance companies, protected a record high of 60,547,000 Americans in 1963. The Health Insurance Institute reports the 1963 figure represents an increase of 27 million people over the number protected a decade earlier.

In addition to the 60,547,000 persons with group hospital expense protection, 60,944,000 also had surgical coverage under insurance company group policies, 42,066,000 had regular medical coverage, and 38,268,000 had major medical programs. Loss of income coverage under group plans of insurance companies protected 23,418,000 at the end of 1963.

### Reports on Tumor Inhibitors

Cissampareine and podophyllotoxin, both extracted from plants, have been shown to possess tumor-inhibiting activity by a group of researchers at the University of Wisconsin.

Reports on the compounds appear in the April issue of the American Pharmaceutical Association's Journal of Pharmaceutical Sciences in two articles from the series "Tumor Inhibitors." The article is by S. Morris Kupchan, A. C. Patel, and Eiichi Fujita.



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## Kent County Society Helps Finance Survey

A grant from the Kent County Medical Society is helping to finance a special study by the Michigan State University Institute for Community Development of the needs and wants of Kent County physically-handicapped citizens.

The Medical Society and four other agencies in the health field are cooperating in this study, which the Grand Rapids Press, in an editorial, called perhaps the most comprehensive survey of its kind in any community in Michigan.

# *Many Ways to Work For Better Government*

After the elections are over, people often halt their valuable voluntary contributions towards better government.

But there are still many services that physicians, their wives and their medical assistants can perform.

What can an individual do to bring about better government?

The most practical answer is: Take part in the art of practical politics.

Following are some down-to-case suggestions on how to participate in the art of practical politics:

Join MD-PAC here in Michigan.

Help organize and participate in a training-in-politics courses.

Serve as discussion leader for training-in-politics courses.

Serve on the public affairs committee of your local society or auxiliary.

Join a political club and participate in its activities.

Work at your party's headquarters.

Join a speakers' bureau to present the facts on issues.

Become a member of your party's research committee and compile information on issues for use in future election campaigns.

Serve on the fund-raising committee of your party.

Give to your party organization and candidates you know personally.

Serve on a candidate's campaign committee.

Help organize mass meetings and rallies.

Help your precinct captain, or become a precinct captain yourself.

Encourage more people to participate in politics in the party of their choice by speaking at church, civic, fraternal and other group meetings.

## *Fewer Merit Scholars Select Science Careers*

The nation's most promising college-bound students are less interested in science and engineering than they were in 1958, the year after Sputnik I was launched. The humanities and social sciences, however, have been gaining in popularity.

These trends were determined by the National Merit Scholarship Corporation through its study of career preferences of about 68,000 outstanding students who were semi-finalists in the Merit program between 1957 and 1963.

Careers in science were selected by 38 per cent of the male and 23 per cent of the female students in 1958, compared with 29 per cent for males and 19 per cent for females by 1963.

### *Writes About Early Grand Rapids Doctor*

A Grand Rapids physician has turned author to write a historical novel about an early Grand Rapids doctor.

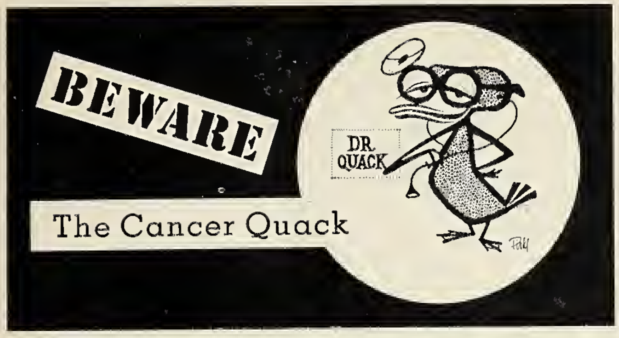
William R. Vis, M.D., in his book "Saddlebag Doctor," tells the story of Charles Shepard, M.D., who arrived in Grand Rapids in 1838 when it was a tiny village, shortly after receiving his diploma from the College of Physicians and Surgeons of Western New York.

Although a novel, the book is steeped in solid historical fact and contains data about medical practices of the 19th century. Dr. Vis has been practicing medicine in Grand Rapids and studying the history of the city since 1918. The book was issued by Wm. E. Eerdmans Publishing Company, Grand Rapids.

### Books on Hearing Offered

A program to provide books on hearing and the hearing sciences for college libraries offering advanced study in audiology will be continued in 1965 by the Beltone Institute for Hearing Research. In 1964, books valued at $3,500 were granted to 43 colleges.

**PUBLIC RELATIONS**



The Michigan Cancer Coordinating Committee offers free an effective cancer warning folder to physicians. For copies, write to MSMS, Box 152, East Lansing, Michigan.

## *Readers Write*

We have just seen the editorial by Doctor McGillicuddy in the March Michigan Medicine, and want to express our thanks for this excellent and forthright presentation. As you well know, articles such as this one do much to increase understanding of our program and reinforce our fund-raising efforts.

It is also good to know that you are planning to use additional material on AMA-ERF's bequest program in a forthcoming issue. We deeply appreciate this assistance.

With kindest regards.

E. M. Steindler
*Assistant Director of Programs*
AMA-ERF, Chicago

This is to advise you that permission has been given to the National Institute of Neurological Diseases to study the approximately 1,100 deaths from malignant neoplasms of the eye, which occurred in the United States during the three-year period 1959 through 1961.

In this study *no relatives of decedents will be contacted*, but the National Institute of Neurological Diseases may contact the attending physicians, hospitals, tumor registry, pathologists, and possibly in a few instances, funeral directors.

This will involve very few persons in Michigan, and we believe that the study has proper safeguards.

Albert E. Heustis, M.D.
*State Health Commissioner*

Thank you for the fine editorial in your January issue about the role played by advertising in our state medical journals. I am referring specifically to your comments about "Does Advertising Pay." I'm sure our staff will find your editorial valuable.

Adelaide K. Davis
*Vice President*
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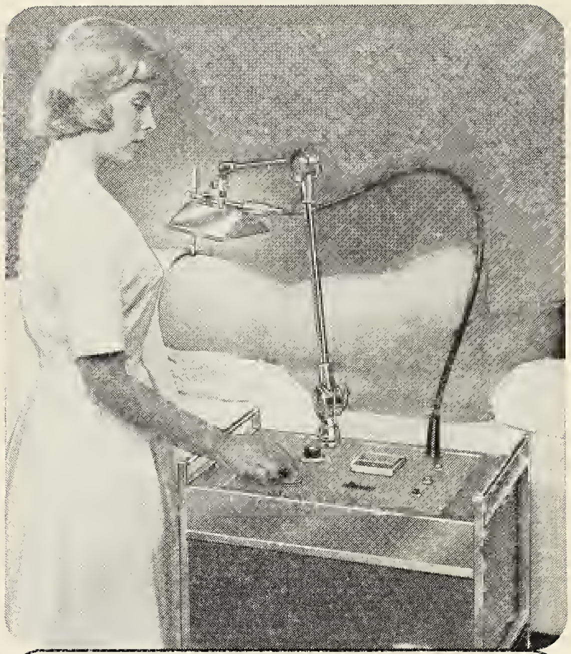

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# — — IN MEMORIAM — —

## DAVID C. BURNHAM, M.D.

David C. Burnham, M.D., 50, Birmingham, died March 9 in Grace Hospital.

Doctor Burnham received his medical degree from the Wayne State University School of Medicine. He was a member of the staff of Grace and Oakwood Hospitals. Doctor Burnham was a Fellow in the American College of Surgeons and a member of the Industrial Medical Association.

## EDWARD DOWDLE, M.D.

Edward Dowdle, M.D., 77, Detroit physician and surgeon, died March 23 at Providence Hospital.

Born in Oswego, N. Y., Doctor Dowdle received his M.D. degree from Cornell University in 1909. Doctor Dowdle practiced medicine in Oswego from 1911 to 1917.

After serving in the Army Medical Corps in Europe during World War I, Doctor Dowdle moved to Detroit where he practiced medicine until his retirement seven years ago. Doctor Dowdle was chief of staff of Providence Hospital in 1938 and a member of the executive committee from 1936-1939.

He was a former president of the Detroit Academy of Surgery, former chairman of the Surgical Section of the Wayne County Medical Society and the Michigan State Medical Society. A member of the founders' group of the American Board of Surgery, Doctor Dowdle was also a fellow of the American College of Surgeons.

Doctor Dowdle was a Life Member of the Michigan State Medical Society.

## FRED GOTTSCHALK, M.D.

Fred Gottschalk, M.D., 73, Detroit physician, died March 16 in Maybury Grand Hospital, Detroit.

A native of Dryden, Doctor Gottschalk was a 1916 graduate of the Wayne State University School of Medicine. He was a resident of Detroit for 55 years, and a former surgeon at Grace Hospital.

During World War I, Doctor Gottschalk served as a first lieutenant in the United States Army Medical Corps.

Doctor Gottschalk was a Life Member of the Michigan State Medical Society.

## LOUIS M. GREEN, M.D.

Louis M. Green, M.D., 57, former Detroit physician, died February 25 at his residence in Dryden.

A graduate of Wayne State University School of Medicine, Doctor Green served his internship at Wayne County General Hospital and took several postgraduate courses in surgery at Cook County Hospital, Chicago. Just prior to his death, Doctor Green was appointed to the associate staff of the Community Hospital, south of Almont.

During World War II, Doctor Green was a medical corps captain and served in the South Pacific. He practiced medicine in the Detroit area for many years and at the time of his death maintained an office in Metamora.

Doctor Green was a member of the American College of Abdominal Surgeons and a member of the public relations committee of the Wayne County Medical Society.

## THOMAS F. KEATING, M.D.

Thomas F. Keating, M.D., 82, eye, ear, nose and throat specialist of Detroit, died March 2 at Herman Kiefer Hospital.

A native of Manchester, Connecticut, and a 1910 graduate of the University of Maryland where he received his M.D. degree, Doctor Keating practiced medicine in Detroit for 42 years. Formerly Doctor Keating served with the U. S. Public Health Service in Alaska and at a Philippine leper colony. He was a former medical adviser to the U. S. consul-general in Hong Kong.

Doctor Keating was on the staff of Mt. Carmel Mercy, St. Joseph Mercy and Marine Hospitals, Detroit. He was a Life Member of the Michigan State Medical Society.

## RUSSELL L. MUSTARD

Russell L. Mustard, M.D., 70, Battle Creek surgeon for the past 34 years and prominent professionally at state and national levels, died April 1, 1965.

A 1924 graduate of the University of Michigan Medical School, Doctor Mustard served his internship and residency at University of Michigan Hospital and remained with the U-M Medical School as assistant professor of surgery until 1929, when he began practice in Battle Creek.

His reputation as an outstanding surgeon extended far beyond his local practice and he lectured frequently at meetings of the American College of Surgeons, which he served as a governor from Michigan from 1953 to 1959.

His work in cancer control was one of his prime interests. He was among the first to stress as the three great needs in combatting cancer: Research, early diagnosis and "mass examination under a free enterprise system." In 1961 Doctor Mustard was given national recognition for his work in this field when he was awarded the American Cancer Society's Certificate of Merit.

Professional affiliations included membership in the Central Surgical Society, the Coller Surgical Society; the Pan-American Surgical Society, International College of Surgeons; and the New York Academy of Science. He was a past president of the Calhoun County Medical Society and had served as chief of staff at both Leila and Community Hospitals. He was a member of Phi Sigma Honor Society; Alpha Omega Alpha fraternity, and Phi Beta Phi medical fraternity.

## JACK ROM, M.D.

Jack Rom, M.D., 52, Detroit internist and professor at Wayne State University, died March 29 in Henry Ford Hospital.

Active in medical affairs, Doctor Rom was a Wayne County delegate to the Michigan State Medical Society House of Delegates and a member of the MSMS Geriatrics Committee.

He was on the Board of Governors of the WSU College of Medicine Alumni and Chairman of the Wayne County Medical Society Committee on Aging. He was a Fellow of the American College of Physicians, the American College of Cardiology, the American College of Allergists, the American Academy of Allergy, the International Association of Allergology, a member of the New York Academy of Science and the Alpha Omega Alpha Honor Medical Society.

Born in Detroit, Doctor Rom received his medical degree from Wayne State University School of Medicine in 1936, and in 1940 was granted his master's degree in internal medicine from the same school. He interned at Detroit Receiving Hospital, and was in residency there from 1937 to 1940, specializing in internal medicine.

At the time of his death, Doctor Rom was chief of internal medicine at Sinai Hospital, Detroit, consultant at Brent Hospital, Detroit, and Veterans Hospital, Allen Park. Doctor Rom also served as attending physician and Chief of the Allergy Clinic at Detroit Receiving and was chief of the medical division at Detroit Memorial Hospital.

Doctor Rom authored many articles on various aspects of disease and treatment.

During World War II Doctor Rom served as a Major in the United States Army and was awarded the Bronze Star.

## OTIS W. SCHORLING, M.D.

Otis W. Schorling, M.D., 41, Rochester physician, died March 2 at Pontiac General Hospital.

A graduate of the University of Michigan School of Medicine, Doctor Schorling was a full time specialist in radiology. He was affiliated with Community Hospital serving the Romeo-Almont area.

During World War II Doctor Schorling served in the United States Army from 1943 to 1946.

Doctor Schorling was a member of the American College of Radiology and the Radiological Society of North America.

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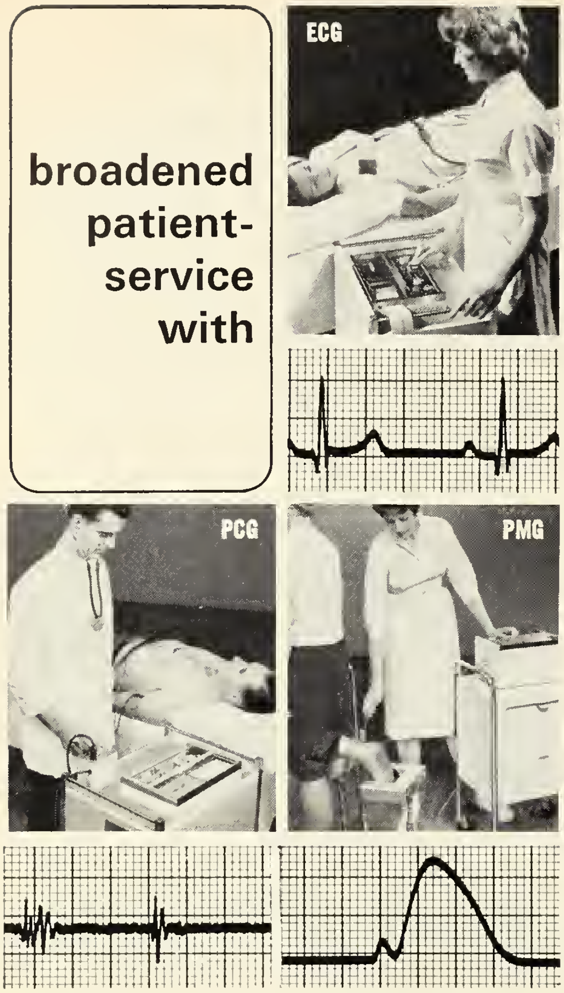

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## EMORY W. SINK, M.D.

Emory W. Sink, M.D., 77, assistant professor emeritus of industrial health at The University of Michigan and ophthalmologist emeritus of the University Health Service, died April 6 at University Hospital.

Born in North Chili, New York, Doctor Sink came to the University of Michigan in 1901 as an assistant in the zoology department and in 1920 received his medical degree from that university. In 1925 Doctor Sink was made an assistant professor of industrial health.

Doctor Sink also had a private practice as a physician and oculist in Ann Arbor.

Doctor Sink was a member of Phi Chi and Sigma Xi medical fraternities, and Phi Sigma, honorary biology, and Delta Omega, honorary public health.

During World War I Doctor Sink served in the E.M.R.C.

Doctor Sink was a Life Member of the Michigan State Medical Society.

## JACOB VAN LOO, M.D.

Jacob Van Loo, M.D., 57, Belding physician and surgeon, died March 11 at his residence.

A native of Grand Rapids, Doctor Van Loo was graduated from the University of Michigan Medical School in 1932. He served his internship at St. Mary's Hospital, Grand Rapids, and worked at Ionia Reformatory for a year before moving to Belding.

Doctor Van Loo served as a major in the United States Air Force during World War II.

## SIGMUND C. SZABUNIA, M.D.

Word has been received of the death of Sigmund C. Szabunia, M.D., 50, on January 18, 1965.

Doctor Szabunia was engaged in the general practice of medicine and surgery in Detroit. He was affiliated with Holy Cross Hospital in that city. Doctor Szabunia received his medical degree from the University of Michigan in 1941.

During World War II Doctor Szabunia served as a major in the United States Army.

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—James C. Doyle, *President,*
*California Medical Association,*
in *California Journal,* Vol. 100, No. 5

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Blood sugar tests are far more accurate than urine tests in detecting possible diabetes, but a firm diagnosis of the disease requires exhaustive re-testing, three leading authorities agree. When the blood sugar level is 140 milligrams per 100 milliliters or higher about two hours after a meal, diabetes is strongly suggested. But a level of low as 110 milligrams usually warrants further investigation, depending upon the patient's age and other factors, the clinicians said. Their observations are reported in a symposium in the current issue of *Diabetes—Research, Detection, Therapy,* a publication of The Upjohn Company.

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### Drugs—One of the Best Buys

One of the best buys (if indeed not the best) in our country today is the purchase of drugs. Considering what one gets for his money, namely, better health and/or less suffering, the cost is most usually well worth every penny spent. It is most unfortunate though that many people believe quite differently. Whatever their reason may be, there frequently lies hidden that unpleasant fact of paying for an unwanted event.—Joseph P. Schaefer, *New Physician,* 14:1, 1965.

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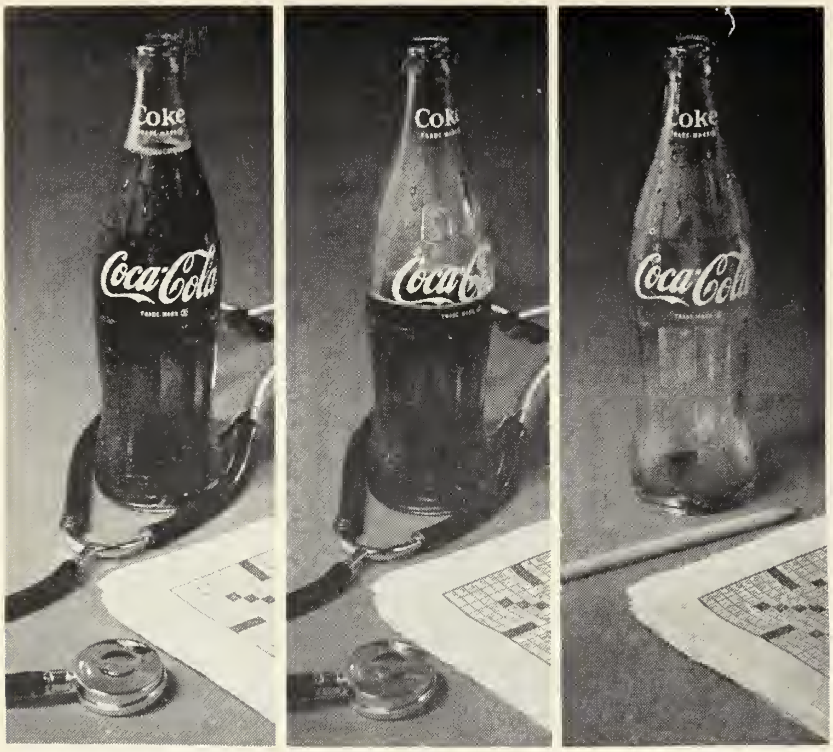

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# Explains M.D. Role Re Disability Benefits

**By David P. Gage, M.D.**
**Chief of Medical Services**
**State Division of Vocational Rehabilitation**

A brief appraisal of the family physician's role in providing medical evidence when his patient applies for Social Security disability benefits is certainly in order at this time.

Congress initiated and passed legislation in 1955 extending the benefits of the Social Security program to individuals under such a severe impairment that they were no longer able to participate effectively in the acceptable labor markets. More than 130 thousand cases have been processed by the state agency in Michigan where the adjudication is performed by the Division of Vocational Rehabilitation, as it is in 44 states.

A very significant element in the processing of any claim for disability benefits lies in the medical report submitted by the family physician. At times it may appear to the physician who initiated the chain of medical data that, no matter what he reports, the case ultimately receives cash benefits. That this is not true should be a matter of record lest the family physician feel that his medical report is given something less than full consideration. Although varying slightly from state to state and within any given state from time to time, the general pattern reveals that approximately one third of all such applicants are denied disability benefits for reason of insufficient impairment!

The Social Security Disability program, as interpreted by our state V.R. agency, continues to require substantial objective detail about any impairment severe enough to prevent further participation in gainful work appropriate to the applicant's education, training, and experience. Consequently, much of the required medical substantiation must be acquired from his family physician. His continuing support in providing these indispensable data will guarantee an equitable provision of benefit when warranted and a considered denial where insufficient impairment exists.

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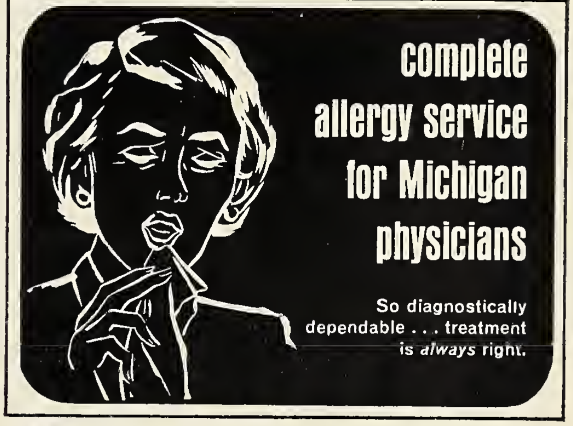

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*"SERVING THE MICHIGAN PHYSICIANS FOR 30 YEARS"*

# Reporting as Ordered

### A Monthly Commentary

**By HUGH W. BRENNEMAN, Executive Director**

It has been traditional for doctors to aim the work of their organizations primarily toward those activities which help the profession better serve the public.

Speaking as a layman, I hope this will never change. But speaking as Executive Director, I can't help feeling that MSMS should pay more attention to the business side of medical practice. There is no desire to lessen emphasis on the scientific program but the factors affecting the delivery of this scientific knowledge to patients are becoming ever more complicated and expensive.

For example:

> If doctors are included under the Social Security act, the cost of their services will be increased by roughly $400 to $500 a year;
>
> If the Michigan Workmen's Compensation Act is changed to require the payment of workmen's compensation by employers of one or more persons, instead of the three or more as is presently the case, it will be necessary for doctors to purchase workmen's compensation insurance on their employees. This will also increase the cost of doing business;
>
> If the Business Activities Tax is continued or a state income tax is placed on top of present taxes this again will increase the cost;
>
> The continuing encroachment upon the field of medicine by government and the complexities of medical administration caused by third party payors has the effect of increasing the cost of office administration which in turn must be passed on.

These are just a few examples. It all adds up to the fact that although the doctors' charges to patients must increase the doctor is getting less "take home pay." Incidentally, another effect of this is to make the group practice of medicine more attractive and the individual private practice of medicine more difficult and costly.

My purpose in mentioning these is not to in any way affect the Society's policy. It is merely that at headquarters these things constantly are apparent whereas they may not be so obvious to the busy doctor who is concentrating on ameliorating pain or saving lives.

## LUCY IS A LADY

Lucy Bartlett, who was My Gal Friday for the Muskegon County Medical Society, is retiring to become a lady of leisure. This action becomes effective July 1st. She will be replaced by an able fellow by the name of Don Fairfield. I won't mention how long Lucy worked for her doctors. Lucy wouldn't like that. But I will say that she was working for some of them before they were born. Everybody up Muskegon way loves Lucy and so do we.

This business of being an executive secretary of a good sized county medical society is no snap and Don will find his hands full if he really moves into the job and assists with the programs that are being offered by county medical societies of similar size in othere areas of the nation.

By the way, the Saginaw County Medical Society did it, too. They hired Carl King to be their executive secretary. I understand some other individuals were momentarily contemplated for this job but fell before the obvious fact that Carl, who has worked with the doctors for many years in the credit field and the telephone answering business, knows more about medical societies' and the medical profession's problems than other laymen. Also, Carl is already well rounded in other respects and consequently makes an ideal choice.

We have heard that the Macomb County Medical Society has hired a new part-time executive secretary, Mrs. Rosemary Terrien. We welcome her as we do all assistance of this valuable variety.

Eleven county medical societies in Michigan now have executive secretaries.

## PR SIDE AFFECTS

When drugs are administered they sometimes have side effects . . . so do public relations efforts. The MSMS newspaper ads, television and radio spots were designed to urge the electorate to express itself favorably on ELDERCARE to its congressmen.

The side affect was that mail received at the state office tripled! Not only did the public talk to its congressmen, but it also talked to the MSMS! By and large, the letters were very encouraging. There was an occasional crank note and in some instances we were able to offer direct help to persons who deserved assistance but didn't know where to go to get it.

As you would guess, the number of phone calls received each day at headquarters continues to grow (seven incoming lines are now in use) and in almost unlimited variety insofar as their subject matter is concerned.

Most of these requests are very serious to the people making them, and even though in many instances the questions would have been more properly addressed to other associations or agencies, we welcome them as opportunities to demonstrate to these people that the doctors' organization tries to be very helpful—and that, cheerfully.

J. D. Brown—Detroit, Southwest

D. F. Hansen—Detroit, Northwest

P. J. McGrath—Flint-Pontiac

A. E. Lee—Detroit, Northeast

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MEDICINE AND SCIENCE

# MICHIGAN MEDICINE

**the journal of the michigan state medical society**

June 1965 • Vol. 64 • No. 6

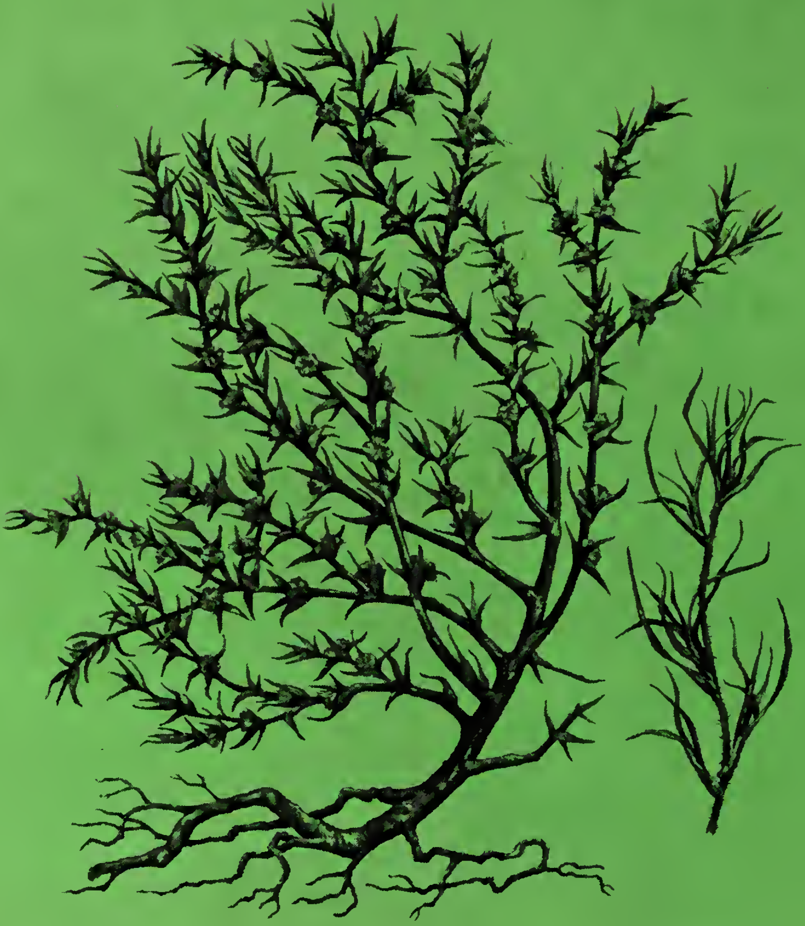
*Cancer Chemotherapy*
*Original Article*

*Newsmen Offer Tips*
*On Public Relations*

*Centennial Series*
*Recalls 1961, 1962*

## THEMES SELECTED FOR CENTENNIAL SESSION SEPTEMBER 19-24, 1965—DETROIT

Sept. 19—Medicine and Religion Day
Sept. 20—Medicine and Business, Industry and Communications Day
Sept. 21—Medicine and Medical Organization Day
**Sept. 22—Medicine and Science Day**
Sept. 23—Medicine and Voluntary Health Day
Sept. 24—Medicine and Government Day



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To Combat Symptoms of Weed-Pollen Allergy

This time-tested agent provides two actions that effectively combat symptoms of seasonal allergy: *Antihistaminic*—relieves sneezing, nasal congestion, itching, and lacrimation. *Antispasmodic*—relieves bronchial and gastrointestinal spasm. **Precautions:** Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this product. Hypnotics, sedatives, or tranquilizers, if used with BENADRYL, should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENADRYL. **Side Effects:** Side reactions, commonly associated with antihistaminic therapy and generally mild, may affect the nervous, gastrointestinal, and cardiovascular systems. Most frequent reactions are drowsiness, dizziness, dryness of the mouth, nausea, and nervousness. BENADRYL is available in Kapseals® of 50 mg. and Capsules of 25 mg. diphenhydramine hydrochloride. The pink capsule with the white band is a trademark of Parke, Davis & Company.

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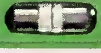

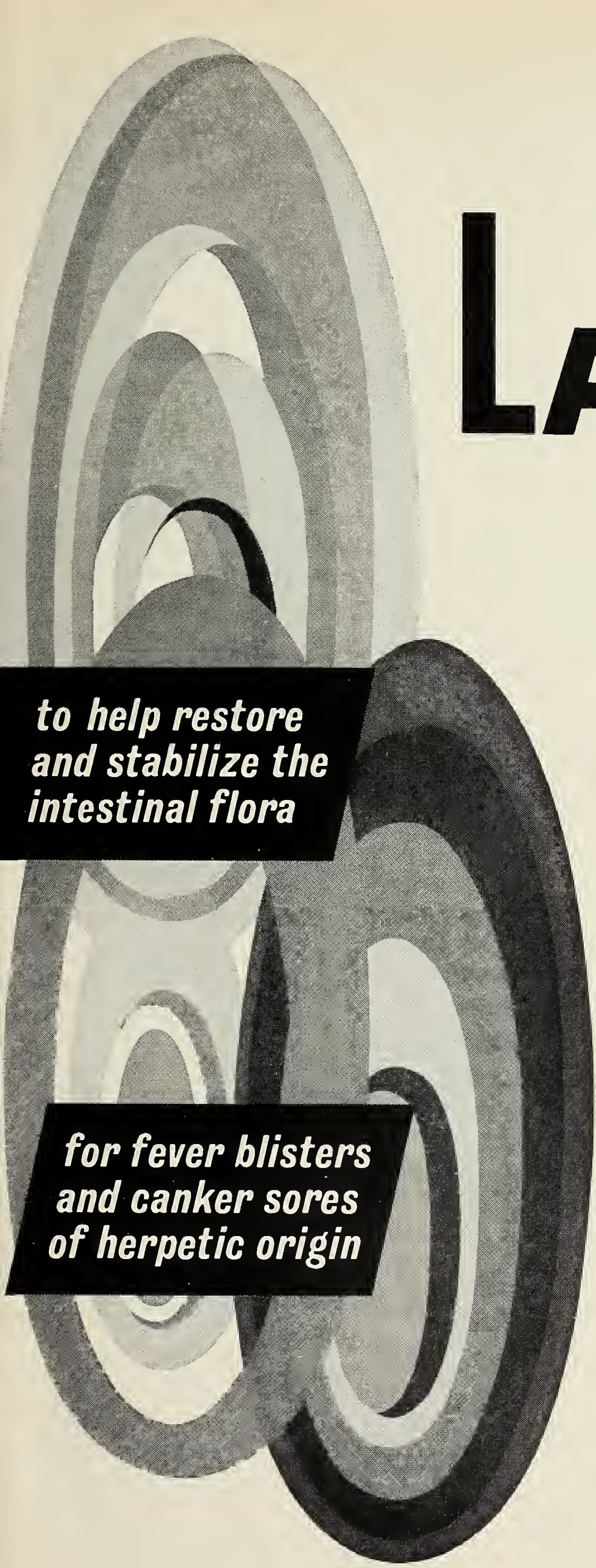

**to help restore and stabilize the intestinal flora**

**for fever blisters and canker sores of herpetic origin**

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## TABLETS & GRANULES

LACTINEX—a viable culture containing both *Lactobacillus acidophilus* and *L. bulgaricus*—was first introduced to help restore the flora of the intestinal tract in infants and adults.[1, 2, 3, 4]

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No untoward side effects have been reported in 12 years of clinical use.

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*(1) Frykman, H.M.: Minn. Med., Vol. 38, Jan. 1955. (2) Poth, E.J.: The J.A.M.A., Vol. 163, No. 15, April 13, 1957. (3) McGivney, J.: Texas State Jour. of Med., Vol. 51, No. 1, Jan. 1955. (4) Stern, F. H.: Jour. of The Amer. Ger. Soc., Vol. 11, No. 3, Mar. 1963. (5) Weekes, D. J.: N.Y. State Jour. of Med., Vol. 58, No. 16, Aug. 1958. (6) Abbott, P.L.: Jour. of Oral Surg., Anes. & Hosp. Dental Serv., Vol. 19, July 1961. (7) Weekes, D. J.: E.E.N.T. Digest, Vol. 25, No. 12, Dec. 1963.*

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Salicylate or steroid therapy can usually be diminished or, in some instances, eliminated.

Psoriatic arthritis responds in the same way as rheumatoid arthritis but the skin lesions are usually not affected either favorably or adversely by treatment.

**Precautions**
Before prescribing, the physician should obtain a complete history and perform a complete physical and laboratory examination, including a blood count.

The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools.

If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time.

**Side effects**
The most common side effects are nausea, edema and drug rash. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug.

**Contraindications**
These include: edema, hypertension, or danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when other potent chemotherapeutic agents are given concurrently because of the increased possibility of toxic reactions; when the patient cannot be seen regularly; when the patient is senile.

*Note:* The physician should be fully aware of dosage, precautions, side effects and contraindications as contained in the complete prescribing information.

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Tablets of 100 mg.

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# MICHIGAN MEDICINE

## the journal of the michigan state medical society

June 1965 • Vol. 64 • No. 6

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Published monthly except two extra issues to be published in October and December, by the Michigan State Medical Society as its official journal at 2642 University Avenue, Saint Paul, Minnesota 55114.

Second class postage paid at Saint Paul, Minnesota.

Yearly subscription rate, $9.00; single copies, 80 cents. Additional postage: Canada, $1.00 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year.

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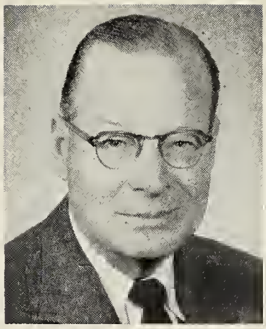


## *the president's message . . .*

### MEDICARE

Comments in rhyme on Medicare
Which passed the House with votes to spare,
The AMA is quite distraught
For most of its efforts went for naught.

The wealthy retired are chuckling with glee
At their $40.00 hospital fee.
And blessed are the younger set
For they shall inherit the National Debt.

The worker's payroll will show no loss
He's sure the tax will come from the boss.
And the hospital census will go a reeling
But then they can hang them from the ceiling.

And bureaucrats there'll be galore
But their employment we won't deplore,
For who knows with the present trend
To them all knees may knock and bend.

The fight we put up was intense and regal
But its nearly a law and almost legal.
The future course sad to relate
Looks like more of the Welfare State.

As the Great Society continues to zoom
With Federal Care from womb to tomb
The pioneers must squirm in space
To see incentive going without a trace.

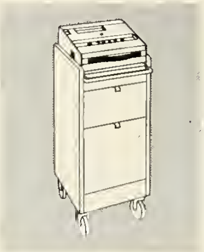
We doctors who have known the thrills
Of gratified patients even with bills,
Resent this invasion of federal wealth
In private field of people's health.

We might feel better abcut the law
If we were consulted or if we saw
Some admission by those who make the rules
That doctors are essential, and not all fools.

Then if I know doctors, and I think I do,
Their concern for patients, they'd pledge anew.
They might not participate or send a bill
But they'd still heal the maimed, the old, the ill.

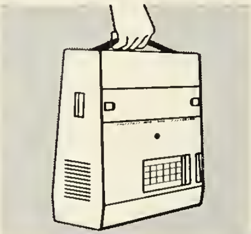
*Oliver B. McGillicuddy, M.D.*

# When the call is for CARDIOGRAPHY...



*in the hospital...*

*in the office...*



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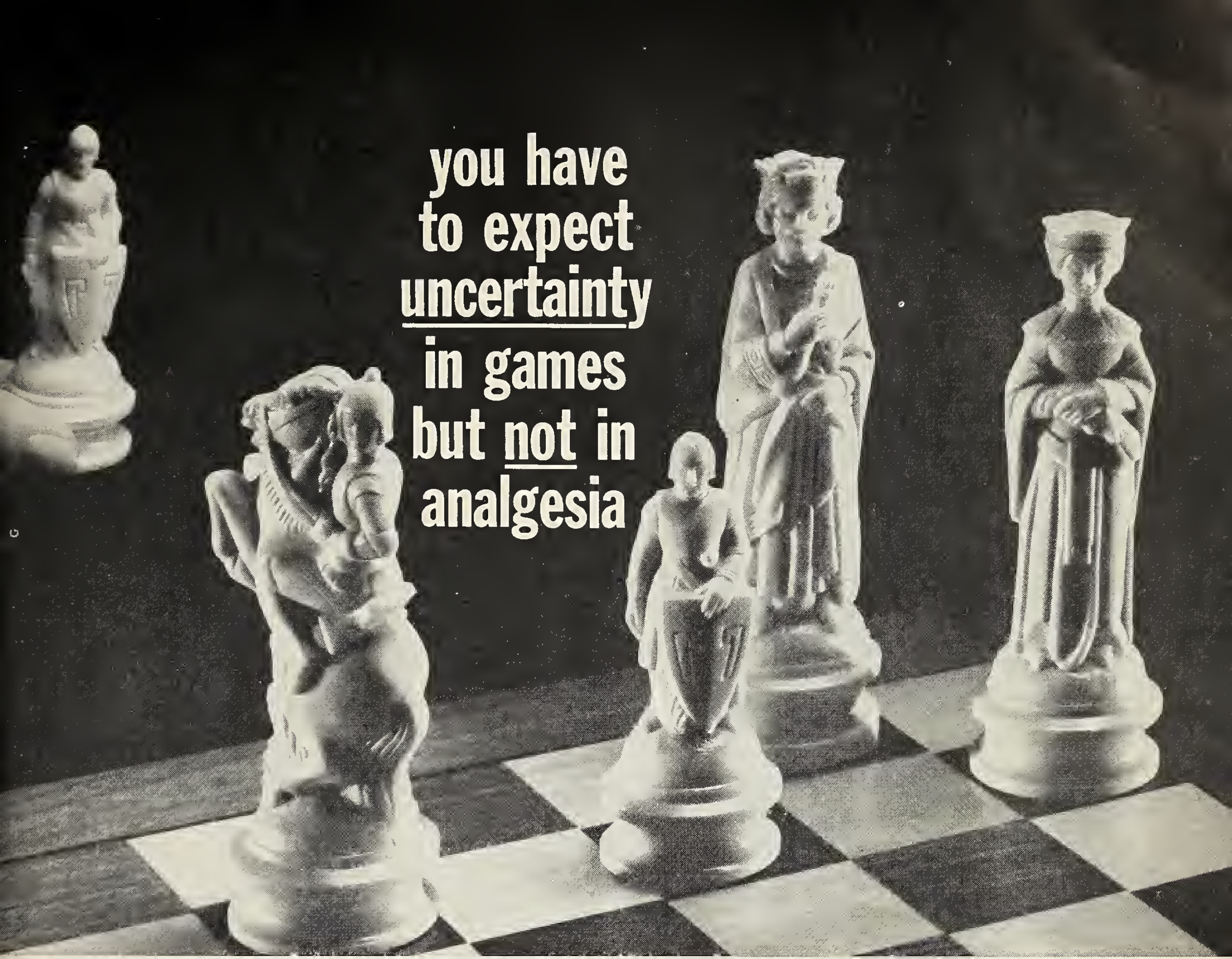

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**Average Adult Dose**—1 tablet every 6 hours.

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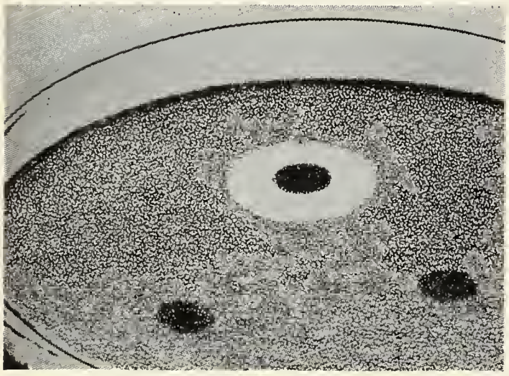

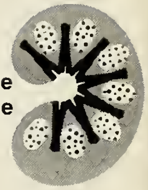

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**Indications:** Urinary tract infections caused by gram-negative and some gram-positive organisms.

**Side effects:** Mainly mild, transient gastrointestinal disturbances; in occasional instances, drowsiness, fatigue, pruritus, rash, urticaria, mild eosinophilia, reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), and reversible photosensitivity reactions. Marked overdosage, coupled with certain predisposing factors, has produced brief convulsions in a few patients.

**Precautions:** As with all new drugs, blood and liver function tests are advisable during prolonged treatment. **Pending further experience, like most chemotherapeutic agents, this drug should not be given in the first trimester of pregnancy. It must be used cautiously in patients with liver disease or severe impairment of kidney function.** Because photosensitivity reactions have occurred in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Bacterial resistance may develop.

When testing the urine for glucose in patients receiving NegGram, Clinistix® Reagent Strips or Tes-Tape® should be used since other reagents give a false-positive reaction.

**Dosage: Adults: Four Gm. daily by mouth (2 Caplets® of 500 mg. four times daily) for one to two weeks. Thereafter, if prolonged treatment is indicated, the dosage may be reduced to two Gm. daily. Children may be given approximately** *25 mg. per pound* **of body weight per day, administered in divided doses. The dosage recommended above for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Until further experience is gained, infants under 1 month should not be treated with the drug.**

**How supplied:** Buff-colored, scored Caplets® **of 500 mg. for adults,** conveniently available in bottles of 56 (sufficient for one full week of therapy) and in bottles of 1,000. **250 mg. for children,** available in bottles of 56 and 1,000.

**References:** (1) Carroll, G.: Urologists' Letter Club, June 1, 1964. (2) McDonald, D. F., and Short, H. B.: Address to the Fourth Interscience Conference on Antimicrobial Agents and Chemotherapy, New York, Oct. 26-28, 1964.

*Winthrop*

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*Notice of change of address should be sent promptly to the Michigan State Medical Society, P.O. Box 152, East Lansing, Michigan.*

### ADVICE TO AUTHORS:

1. Address scientific manuscripts to Editor, Michigan Medicine, C. J. Tupper, M.D., 2490 Adare, Ann Arbor, Michigan.

2. Submit original, double-spaced typewritten copy and one carbon copy on letter size (8½ x 11 inch) paper.

3. On page one, include title, authors, degrees, academic titles, and any institutional or other credits.

4. Authors are responsible for all statements, methods, and conclusions. These may or may not be in harmony with the views of the Editorial Staff. It is hoped that authors may have as wide latitude as space available and general policy will permit. The Publication Committee expressly reserves the right to alter or reject any manuscript, or any contribution, whether solicited or not.

5. Illustrations should be submitted in the form of glossy prints or original sketches from which cuts, or plates, will be made by the Journal. The Journal will pay the first $25 of the engraving bill, and the author shall pay the balance. An estimate of the cost will be submitted to authors before cuts are ordered.

6. References will ordinarily be limited to seven in number. Exceptions may occassionally be made.

7. Contributors will be notified as soon as practical if a manuscript is accepted for publication. Unused manuscripts will be returned. Every care will be taken with the submitted material but the Journal will not hold itself responsible for loss or damage to manuscripts.

8. Articles should ordinarily be less than four printed pages in length (3000 words).

9. References should conform to *Cumulative Index Medicus,* including, in order: Author, title, journal, volume number, page, and year. Book references should include editors, edition, publisher, and place of publication, as well.

10. Specify address to which galley proof should be sent. Proofs will be mailed to authors for correction before publication and should be returned to the editor in 48 hours. If proofs approved by the author are not received by the editor prior to deadline, publication of the article will be cancelled for that issue.

11. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.

12. It is understood that material is submitted for exclusive publication in Michigan Medicine.

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**BREAKING NEWS — 417-420**

# NEWS BRIEFS

When the ballots were counted at the Battle Creek spring election, **Fred Melges, M.D.**, led the field of 11 candidates to the city commission. This was his first bid for public office.

The Beth Moser Mental Health Clinic in Jackson at its recent three-day Institute on Family Treatment, drew more than 250 psychiatrists, psychiatric social workers and psychologists from throughout the state. **Jose J. Llinas, M.D.**, medical director, and **Peter Mitchell, M.D.**, administrative director, were co-chairmen.

Co-chairmen for the recent Children's Hospital Clinic Days at Detroit were **Charles Whitten, M.D.**, director of the General Clinical Research Center there, and **Joseph Fischoff, M.D.**, Senior Psychiatrist there. It was incorrectly reported in the April issue that Louis E. Heideman, M.D., was the chairman. Members of the committee included **Doctors Clifford D. Benson, John R. Birmingham, John J. Pollack, Paul V. Woolley, Wolf W. Zuelzer** and **Louis E. Heideman.**

The new president of the Michigan Rheumatism Association is **Chester H. Adams, M.D.**, of Flint.

The National Vitamin Foundation has a new chairman of the executive committee—**Herbert H. McDade, Jr.**, director of sales planning for the Upjohn Company.

A $7 million complex, near the Wayne State University School of Medicine, is being planned by the University of Detroit. A non-profit corporation will seek federal funds to help finance three structures, a research facility, an eight-story housing center for the elderly and a 15-story convalescent center.

About 1,000 ninth graders visited the Pawating Hospital at Niles for the annual Career Fair. Speakers included **Walter Daily, M.D.**, of Niles.

**Hygroton®**
**brand of chlorthalidone**

**the long-acting diuretic**

**Indications:** Many types of edema involving retention of salt and water.
**Contraindications:** Hypersensitivity and most cases of severe renal or hepatic disease.
**Precautions:** Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
**Side Effects:** Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
**Average Dosage:** One tablet (100 mg.) daily with breakfast.
**Availability:** Tablets of 100 mg. in bottles of 100 and 1000.
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*Dorhout Mees, E.J., and Geyskes, G.G.: Acta med. scandinav. 175:703, 1964.

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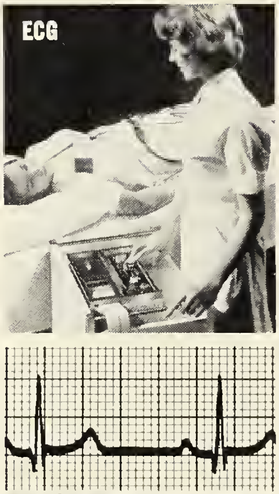

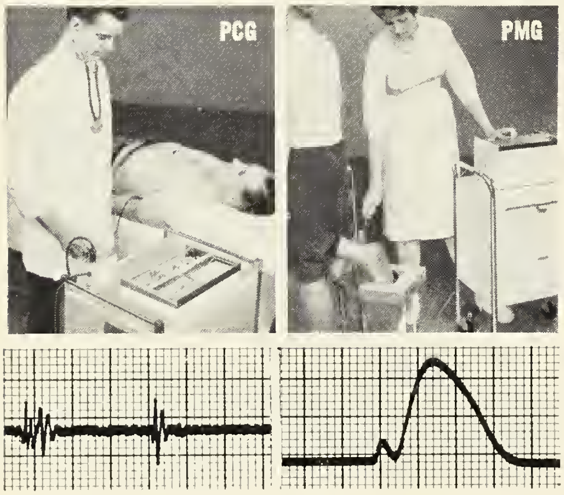

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Serving as chairman of the Reference Committee on Hospitals at the American Academy of General Practice Congress was **Clark W. Rogers, M.D.,** of Battle Creek.

**Richard Sterba, M.D.,** spoke at the last meeting for the current year of the Active and Associate Medical Staff of the Haven Hospital and Psychiatric Center, Rochester. Doctor Sterba's topic was "Have Symptoms Changed Over the Years?"

A community recognition banquet recently honored **Charles TenHouten, M.D.,** practicing physician at Paw Paw for 34 years and longtime resident of the village. Attendance at the school was limited to 300.

**Edwin Prentice, M.D.,** will represent the Muskegon County Medical Society on the newly formed Community Hospital Planning Council, the first to be formed outside of Detroit. Doctor Prentice was named as chairman of the community-wide group, organized to provide the best hospital care, and to eliminate duplication of facilities.

Among the recent Decision television programs produced by the Michigan Association of the Professions was one on "Hearing and You" with **Royal Hayden, Jr., M.D.,** Detroit.

The one-day Michigan Society of Obstetricians and Gynecologists scientific program at the University of Michigan Medical Center heard **F. Jackson Stoddard, M.D.,** a former U-M resident physician now at Marquette University, deliver the R. L. Haas Memorial Lecture. He spoke about transient adrenal virilism.

North Ottawa county schools during May heard talks by Ottawa County physicians about smoking and health. Among those participating were **Doctors Frank Groat, John Kitchel, Dennis Harvey, Jack Henderson, Bernard Veenstra** and **Peter De-Vries.**

Speakers during May on the several Michigan Health Council radio and television programs included—**Peter Walsch, M.D.,** Saginaw, on TB Treatment over WNEM-TV; **E. J. Brenner, M.D.,** Mt. Pleasant, on Glaucoma Detection over WWTV and WWUP-TV, and **George Maniaci, M.D.,** Gladstone, on Mental Retardation over WWTV and WWUP-TV.

Smith Kline & French Laboratories' Foreign Fellowships will send **Glenn D. Verbrugge,** a University of Michigan Medical School junior, and his wife, a medical technologist, to South Korea, and **Lionel J. Hurd,** a junior at WSU Medical School, and his wife, a nurse, to an African mission hospital.

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*Contraindications:* (1) Hypersensitivity to penicillin. (2) Infections by penicillinase-producing staphylococci and other penicillinase-producing organisms.

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*References:* 1. Editorial. Brit. M. J. *ii*:223 (July 22) 1961. 2. Rolinson, G. N., and Stevens, S.: Brit. M. J. *ii*:191 (July 22) 1961. 3. Stewart, G. T., *et al.*: Brit. M. J. *ii*:200 (July 22) 1961. 4. Brown, D. M., and Acred, P.: Brit. M. J. *ii*:197 (July 22) 1961. 5. Batchelor, F. R., *et al.*: Nature *183*:257, 1959. 6. Knudsen, E. T., *et al.*: Brit. M. J. *ii*:198 (July 22) 1961. 7. Doyle, F. P., *et al.*: Nature *191*:1091 (Sept. 9) 1961. 8. Acred, P., *et al.*: Brit. J. Pharmacol. *18*:356, 1962. 9. Harrison, P. M., and Stewart, G. T.: Brit. J. Pharmacol. *17*:420, 1961. 10. Editorial. Lancet *ii*:723 (Oct. 5) 1963.

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The choice of the proper cancer chemotherapeutic agent is only one of several important decisions in treating the patient with metastatic malignancy. Questions arise concerning need for treatment, optimum time for treatment, how to weigh toxic side effects versus the amount of palliation expected, and how long to continue treatment. Emphasis is placed on the importance of tissue diagnosis, complete clinical evaluation, knowledge of rate of progression of disease, and criteria for evaluating subjective and objective response.

# Cancer Chemotherapy

## *The Importance of Selection of the Patient*

**By Donald R. Korst, M.D., F.A.C.P.***
**Of Ann Arbor**

During a 15-year period the importance of cancer chemotherapeutic control of many patients with malignant disease has increased in importance. There are currently available to all physicians a number of proven helpful drugs. For instance, there are six alkalating agents, three antimetabolites, three radio-isotopes, many steroids, and several plant alkaloids with anti-neoplastic properties. Their uses have been discussed and reviewed in the current medical literature.[1,2]

The knowledge of the indication, the usefulness, and the toxicity of these drugs is important for every physician to know. However, equally important is the clinical decision as to which patient should be selected for cancer chemotherapy and when the treatment should be started.

By definition, then, cancer chemotherapy in its present state is the oral, intravenous, or intra-arterial administration of chemicals and drugs to patients with regional or disseminated malignant disease in order to produce remission or palliation. Five-year remissions or possible cures have been induced in an occasional woman with choriocarcinoma or a child with acute leukemia. The purpose of this report is to answer some frequently asked questions directed to a cancer chemotherapy service staff.

* * *

*Why bother to treat cancer with advanced disease?*

In most patients with leukemia, lymphoma and perhaps 30 per cent of the patients with metastatic carcinoma, a significant degree of palliation can be achieved with rather slight toxic side effects. Useful and productive life can be prolonged. The dreadful, painful period of the bedridden cancer patient receiving morphine at frequent intervals can be significantly altered. Death with dignity for the cancer patient has been greatly enhanced by the judicious use of palliative antimetabolites. Approximately one-third of the patients today, at the time of the first diagnosis of malignant disease, are candidates and will be benefited by chemotherapy. A positive approach to treatment of these hopeless conditions by the medical profession has provided a great deal of comfort and confidence to cancer patients and their families. It has greatly reduced the threat of the "cancer quack clinic" and its bizarre claims.[3]

Figure 1 shows the clinical course of a woman with adenocarcinoma of the ovary. At any point beyond the patient's two effective operations she could have been allowed to develop the complications of a large liver metastasis. However, there

**SCIENTIFIC PAPERS**

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*Department of Hematology and Chemotherapy, St. Joseph Mercy Hospital, Ann Arbor, Michigan.

**TABLE I. CRITERIA OF RESPONSE**

**OBJECTIVE**

- Palpable or x-ray measurable tumor(s)
- Blood and marrow function
- Liver function:
    - Enzyme studies
    - Dye excretion
    - Prothrombin time
    - Scintiscanning
- Endocrine function
    - $I^{131}$ Thyroid Uptake
- Renal function
- Biochemistry
    - Serum proteins
    - Enzyme fractions
    - Uric Acid
- Lymph node and spleen size
    - Scintiscanning
    - Lymphagiography

**SUBJECTIVE**

| | |
|---|---|
| Subjective Pain: | Bone , muscle, nerve, etc. |
| Weight: | A sensitive guide |
| Symptoms: | Well being, appetite, weakness, hematuria, cough, hemoptysis, etc. |

**PERFORMANCE STATUS (KARNOFSKY SCALE)**

| | | |
|---|---|---|
| Able to carry on normal activity; no special care is needed. | 100 | Normal: no complaints; no evidence of disease. |
| | 90 | Able to carry on normal activity; minor signs or symptoms of disease. |
| | 90 | Normal activity with effort; some signs or symptoms of disease. |
| Unable to work; able to live at home, care for most personal needs; a varying amount of assistance is needed. | 70 | Care for self; unable to carry on normal activity or do active work. |
| | 60 | Requires occasional assistance, but is able to care for most of his needs. |
| | 50 | Requires considerable assistance and frequent medical care. |
| Unable to care for self; requires equivalent of institutional or hospital care; disease may be progressing rapidly. | 40 | Disabled; requires special care and assistance. |
| | 30 | Severely disabled; hospitalization indicated, although death not imminent. |
| | 20 | Very sick; hospitalization necessary; active supportive treatment is necessary. |
| | 10 | Moribund; fatal processes progressing rapidly. |
| | 0 | Dead. |

was significant response to three courses of chemotherapy and probable prolongation of life for several years during which time the patient was at work and near 100 per cent performance status.

Today the physician would be remiss to overlook possible chemotherapy in any leukemia, lymphoma or carcinoma of the breast, ovary, colon, testes, bladder, thyroid, prostate, uterus, and some regional forms of squamous cell carcinoma.

* * *

*Does treatment ever prolong life?*

Evidence being accumulated suggests that a prolonged median survival in certain diseases is apparent in chemotherapy-maintained patients. For the first time, five-year cures are documented in choriocarcinoma and recent data from a cooperative chemotherapy group has shown an increased survival in multiple myeloma.[4,5]

*Will you accept a patient for chemotherapy with metastatic disease who does not have a biopsy?*

The answer to this should be loud and clearly, No. Frequently we ask for rebiopsy or even laparotomy if an interval of several years has passed since the original diagnosis was made. Tissue types, particularly in lymphomas, may change and a second primary carcinoma may occur. Several cases are reported here to emphasize the hazard of treating the patient without a definite tissue diagnosis.

### CASE I

A 65-year-old white male, shown in Figure 2, was admitted to the hospital because of hemoptysis.

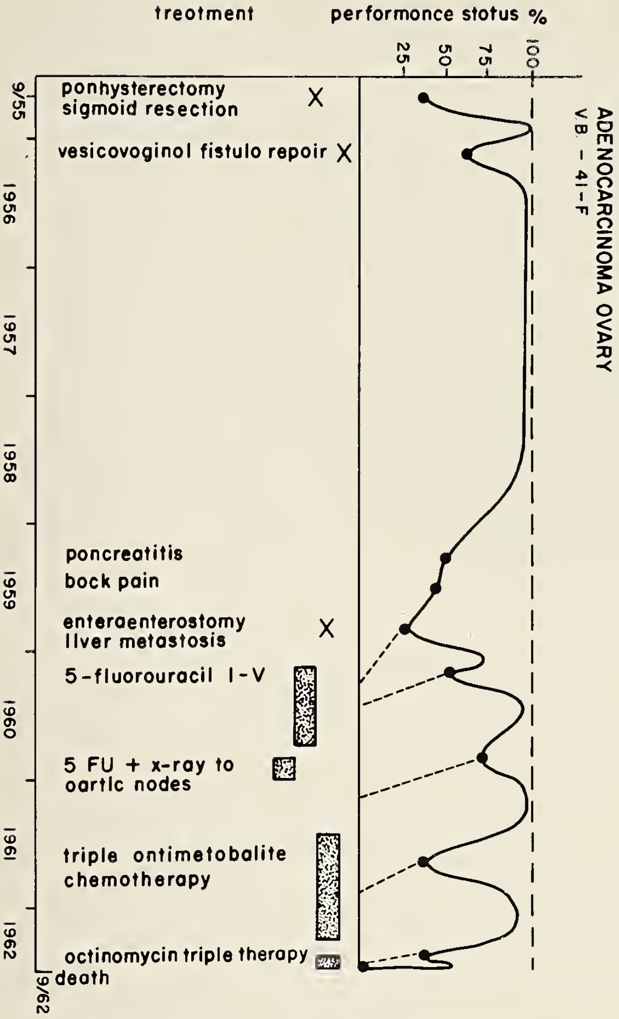

Fig. 1. Clinical course of a patient with adenocarcinoma of the ovary.

THE AUTHOR
Donald R.
Korst, M.D., F.A.C.P.

He was found to have hilar prominence and infiltration in the right lung and radiographic changes in a vertebra. He was a heavy smoker and had undergone some weight loss. Sputum studies were negative, but it was felt that he had carcinoma of the lung with metastasis to the spine. He was not considered to be a candidate for resection and was treated with x-ray therapy and 5-Fluorouracil. His response was dramatic with prolonged improvement. Four years later he was admitted to the hospital with a fatal pulmonary embolus. At autopsy no evidence of carcinoma was found in the lung. There was old pleural thickening from previous infections and the lesion in the spine was Paget's disease. In summary, this case could have represented a dramatic response to combined cancer treatment, but in retrospect, the patient probably never had cancer at all.

## CASE II

A 55-year-old white male was admitted to the hospital because of gastric symptoms (Fig. 3). He had had some recent weight loss and was mildly anemic. An upper gastrointestinal series was inter-

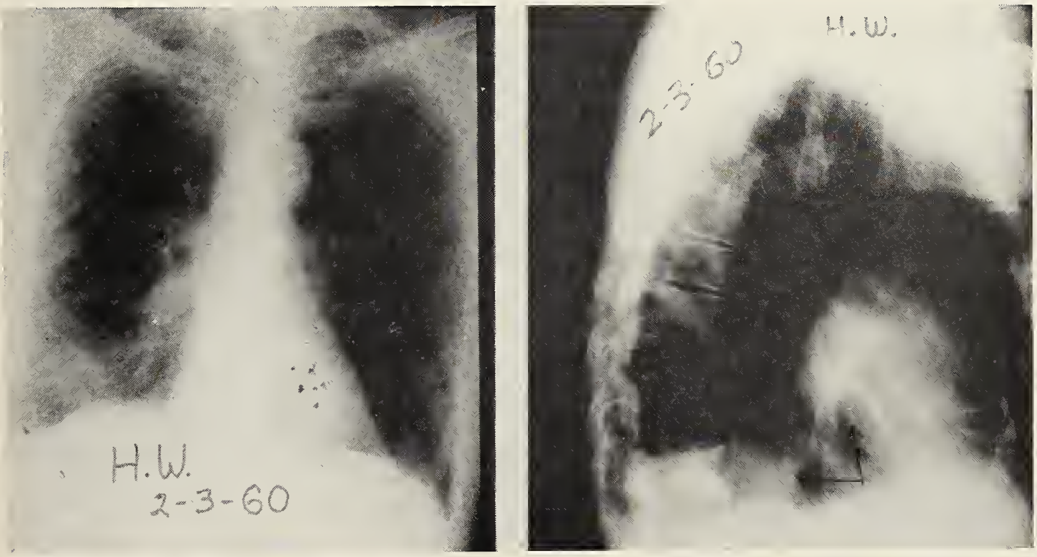

Fig. 2. False positive diagnosis of carcinoma of the lung in a man with pneumonitis and Paget's disease of the spine.

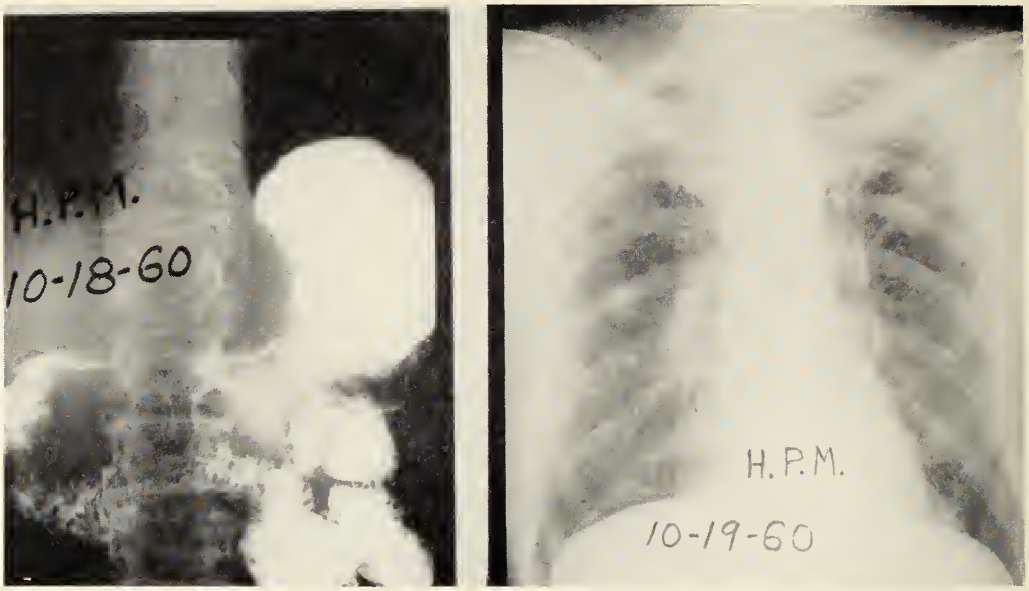

Fig. 3. False positive diagnosis of carcinoma of the stomach in a man with chronic gastritis and old healed tuberculosis.

preted by several observers as abnormal and compatible with gastric tumor. X-ray of the chest revealed bilateral nodular lesions and the initial clinical impression was that of carcinoma of the stomach with metastasis to the lungs. He was seen by the cancer chemotherapy service with a request to treat him. Gastric washings were obtained and were negative. It was thought that this man should have a more definitive diagnosis made before cancer chemotherapy was started. At laparotomy, it was found that the stomach was involved with chronic gastritis and enlarged rugal folds without evidence of cancer. Chest x-ray taken several years prior to 1960 was obtained and revealed the stable nodular lesions.

**Summary:** This was a grateful patient, who could have been another dramatic response to chemotherapy.

* * *

*How do you know when a patient needs chemotherapy?*

The stage of disease and the effect on the patient must be evaluated. In addition to the history and physical examination obtained on a regular follow-up basis, we use the following laboratory aides at indicated intervals: The BUN and urinalysis for evaluation of renal function; alkaline phosphatase, prothrombin time and LDH for evaluation of hepatic function. If one of these is abnormal, we also obtain a liver excretion test of BSP. The x-ray of the chest and skeletal survey in some cases is important. A careful evaluation of temperature, weight and hemoglobin values is important in every case. Probably the most important single fact to know about the patient is the rate of progression of his disease. There are wide variations and individual differences of rate of tumor growth and metastases, although the histologic cell type may be the same. This may be due to host resistence or due to the biologic nature of the tumor. Patients seen with multiple pulmonary metastases or easily palpable tumor masses have been observed to be relatively stable for many months to years. It would

### TABLE II. DEGREE OF RESPONSE

I. **Good Remission:** Patient shows improvement for 60 days or more by significant changes in all subjective categories, performance status improved 20% or more, and a favorable objective change by three or more measures. Complete remission is no evidence of disease.

II. **Partial or Moderate Remission:** A favorable change of 50% in the subjective and objective category.

III. **Mild Remission or Subjective Improvement Only:** No significant change in objective categories; however, the patient had a decrease in pain, improved general attitude, and a slight improvement in performance status.

IV. **No Progression:** No change for two months or more when rate of progression of disease is known.

V. **Failure To Alter Progression of Disease.**

VI. **Adequate Trial:** Acute Leukemia—3 weeks
Lymphoma—4 weeks
Carcinoma—6 weeks
Myeloma—8 weeks

be a shame to upset this biologic equilibrium or claim an enthusiastic drug response by premature introduction of chemotherapy. The progression of disease is determined by careful and regular evaluation of the patient and an appreciation of the clinical course of the various types of malignant diseases. There is seldom an urgent need to commence palliative treatment.

* * *

*How do you know if the treatment is helping or when to stop?*

We have accepted certain criteria of subjective and objective response in order to compare treatment from one report to another. The patient should show a measurable change in a four- to eight-week period before making a decision to continue or stop treatment. These criteria are demonstrated in Table I.

* * *

*How is a response measured or reported?*

The degree of response is determined in each patient with each treatment as shown in Table II, The Degree of Response.

* * *

*What about drug toxicity?*

The toxic side effects of the newer drugs have been much reduced by refinements in the methods of administration and dosage. As with all new procedures, experience has improved the risk and decreased the drug toxicity. The occurrence of leukopenia is now used to measure the effective dose of an antimetabolite and it is unusual that bone marrow depression is not completely reversible.[6]

* * *

*What about new investigational drugs?*

There are a number of types of cancer where present available drugs are ineffective. To name a few, fibrosarcoma, hypernephroma, melanoblastoma and lung carcinoma. In these situations, it seems warranted to use a new promising, but unexplored, compound under the supervision of an experienced clinical investigator in the field of cancer chemotherapy.

* * *

*Should the patient know his diagnosis?*

I find it difficult to supervise a patient through a course of chemotherapy or radio-therapy without him fully understanding the entire situation. The current interest of the public, press, literature, and television in medical disease makes it even more difficult. Most patients are very grateful that you have been very frank with every detail of their progress.

*What is the future and who should follow the patient?*

The patient with malignant disease deserves the follow-up attention of an entire medical team. The family doctor, the surgeon, the radiotherapist and the chemotherapist should all advise throughout the entire course of the disease. It is discouraging to see a patient in the terminal stage of cancer and be asked if anything will help, when six months earlier significant palliation might have been induced. I have yet to see a patient with malignant disease complain about too many consultations.

The future is better each year and the time has arrived to consider all modalities of treatment, surgery, radiotherapy, chemotherapy, alone or in combination, for an all-out effort to improve survival and palliation to the cancer patient. The total care of the patient is the responsibility of the entire medical team.

## SUMMARY

Criteria for Selecting the Patient for Cancer Chemotherapy.

1. The tissue diagnosis of malignant disease must be established.
2. Complete clinical evaluation to determine extent of disease and effect on renal, hematologic, hepatic functions, etc., should be carried out prior to treatment.
3. The course and rate of progression of the disease must be known.
4. The possibility of remission or palliation must be weighed against drug toxicity and the extent of the therapeutic procedure.
5. The patient must know his diagnosis and accept the limitations and toxicity of the treatment.

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# Emotional Factors In Headache

**By R. W. Waggoner, M.D., Sc.D.**
**Of Ann Arbor**

Since headache is one of the most pervasive of all symptoms and may indicate pathology of all degrees of severity from relative unimportance to that of a very serious prognosis, it becomes clear that the symptom may have its source in many different pathological processes.

It is important to recognize psychological factors which may be involved in the emotional etiology of headache. The most frequent source of this particularly annoying and sometimes incapacitating symptom is an emotional problem of some kind.

A young man complains of severe headache whenever he tries to study a subject in a course he knows his family wants him to take, but the pain disappears when he reads a novel.

* * *

IS THE PAIN a fake? Of course not, it is a reaction to the guilt he feels for not being able to satisfy his parental wishes and, at the same time, is an expression of the resentment he feels toward his parents when they say he can follow any career he desires, and then pressure him to follow their plans for him.

A second example: what is described as migraine by a patient is often not migraine, but functional headache. Thus, a man of forty-one with an excellent record in college and in the Navy went to work for his father-in-law, where there was much pressure in business. He developed headaches described as migraine and associated with abdominal pain which improved greatly with psychotherapy. He was resentful of his father-in-law's demands, but afraid to get out on his own; the result, frustration and hostility which he dared not manifest outwardly.

* * *

SUCH COMMON cliches as "he gives me a pain in the neck," or "she gives me a headache" are expressions of popular awareness of its psychogenic origin. Tension, with neck muscle pain, may become a headache. As a matter of fact, many authors have emphasized that emotional factors may precipitate or dramatically influence the course of migraine. The psychological aspects of migraine should be considered essentially the same as that of any other type of headache, the physiological mechanism being the significant difference.

That headache of emotional origin is not limited to adults is evidenced by numerous comments in the literature such as, "Having an acute emotional upset as a cause of headache is in the author's experience, common in children after the age of six."[1] Another author suggests that headache is a common complaint of children and either is an indication of somatic illness, a manifestation of fatigue, a reaction to worry or disappointment or of hypochondriacal nature.[2]

Various authors emphasize the factors of fatigue and tension related to conflict in family life, parental rejection, strictness and rigidity in training, particularly when this strictness is imposed without evidence of affection. Symptoms may be in reaction to parental pressure to excel in school.

* * *

HEADACHE IS OFTEN seen as evidence of, or accompanying depression in the child. In the child this may symbolize, "I have no mother or father. What have I done to cause me to lose them?" The reaction to this feeling of guilt is the need for atonement and restitution. Headache with its discomfort is an excellent defensive maneuver for this stimulus. When children complain of headache or other physical symptoms only on school days, the parent or the physician may make the assumption that this is a consciously acquired symptom.

It should be remembered, however, that the stress of school activity can produce such a symptom on an emotional basis, and that for the child the symptom can be just as unpleasant as though it were due to a physiological disorder.

* * *

FURTHERMORE, IT SHOULD be kept in mind that the process of identification is especially significant. Thus, if a parent frequently complains of headache, it is not difficult to understand how this can be easily acquired by the child through a process of identification and in reaction to a seemingly small amount of stress.

A most interesting hypothesis with regard to headache has been advanced by Schmidt, in an article entitled, "Deep Hostility, the Nose and Headache," who states as follows: "Hostility is a great cause of headache. This paramount fact has some interesting applications when applied specifically to the psychodynamic interrelationships caused by emotional states of the nasal organ."[3]

The question of hostility as a part of the dynamics in the production of headache will be discussed later, but to return to Schmidt's comments, he points out that the tissue of the nasal turbinate is erectile tissue innervated by cervical sympathetic fibers. He also points out that nasal hypersensitivity may accompany menstruation, pregnancy, and even to a minor degree, erotic activity and that these manifestations may be magnified and produce symptoms when conflicts are associated with these functions. He points out that this is significantly related to unsatisfied needs which cannot be adequately gratified. The patient then feels unconscious guilt which leads to self-punitive action. At the same time, hostility develops which is directed both inward to the patient himself as well as to the outer world. This rage reaction causes nasal swelling and obstruction which, in turn, may lead to severe headache. He also points out that the nose responds sensitively to the storms and stresses of life on the deepest emotional levels.

If the basic demands of life are frustrated repeatedly, such stress can result in actual, significant and chronic pathology in the nose. Thus, emotional stress and the physical reaction to it can be manifested by chronic nasal pathology according to this author.

* * *

DEPRESSION MAY not be clinically expressed as such but may stimulate a considerable number of disease states. Many physical complaints or manifestations are actually evidence of an underlying depression of mild to serious degree. The clinical picture of depression in terms of psychomotor retardation and dejection does not have to manifest itself as may be expected. As a matter of fact, Diamond states, "Depression is a great masquerader of modern medicine just as syphilis was in earlier times."[4] He emphasized that the physician should take a careful history of the patient with the presenting symptom of headache because in this way unsuspected depression may be unmasked and effectively treated.

Most of us have a tendency to think of the cause of disease as something tangible which can be identified and removed or destroyed. Doctor Warthin, Professor of Pathology at the University of Michigan years ago, used to criticize a diagnosis which would not satisfactorily explain all symptoms of which the patient complained. This kind of a philosophical approach to medicine is no longer acceptable since we know that many factors are involved in the etiology of symptom complexes. We know that some people may be exposed to infection and not develop the typical reaction while others, similarly exposed, promptly become ill.

An individual's resistance to infection may also vary from time to time; that is to say, he may be susceptible at one time and not another. Such variations in reaction are due to a number of factors, not the least of which is the emotional one.

* * *

ONE OF THE MOST common factors resulting in a disturbance of emotional homeostasis is object loss or frustration which may be real or symbolic. It is usually expected that the individual will react to a loss or frustration by utilizing his own self-control rather than by the development of some kind of symptoms which will lead him to seek help from the physician. Since the usual response to loss is grief, sadness (sometimes called "normal depression") or anger and, since these reactions sometimes are not or cannot be expressed outwardly or openly, they are then turned back upon the individual (internalized) and reappear as symptoms.

Such symptoms or complaints may suggest an organic or physiologic source. A manifestation of this kind can vary from that of headache to "colitis" with almost any kind of physical symptomatology which does not quite fit the apparent syndrome. Headache is probably the most common manifestation of this type of reaction. Once such a pattern of response has been established, it becomes more or less self-perpetuating.

The meaning of this is that unresolved anger or frustration becomes a mechanism leading to tension and anxiety which may manifest itself in various ways and commonly as headache. Furthermore, these patients are often very difficult to treat because this is a defense they need to satisfy their dependency needs and they unconsciously refuse to get well unless some other acceptable source of

*(Continued on Page 409)*

THE AUTHOR
R. W. Waggoner, M.D.

**CLASSIFICATION OF THORACIC WALL ABNORMALITIES**

| I. Developmental | II. Infectious | III. Traumatic | IV. Neoplastic |
|---|---|---|---|
| A. Osseous and cartilagenous | A. Acute | A. Closed | A. Primary<br>1. Benign<br>2. Malignant |
| B. Soft tissues | B. Chronic | B. Open<br>1. Missile<br>2. Thermal<br>3. Blunt | B. Secondary<br>1. Metastatic<br>2. Implanted<br>3. Contiguous |
| C. Combined | | | |

# Abnormalities of the Thoracic Wall: Classification and Problems

**By Charles L. Adams, M.D., F.A.C.S.***
**Of Lansing**
**And W. Clayton Davis, M.D., F.A.C.S.****
**Of Pittsburgh**

All too frequently, the structural and functional changes resulting from abnormalities of the chest wall are not recognized nor appreciated for their dangerous potential. This may lead to no treatment, delays in therapy or inadequate intervention. It is the purpose of this paper to present a complete clinical classification of all thoracic wall abnormalities and utilize it to emphasize pitfalls in diagnosis, pathology and therapy.

## *I. Developmental*

Pectus excavatum (funnel chest, trichterbrust) is a developmental anomaly of the anterior chest wall in which the sternal body forms a depression. The etiology has been a point of controversy,[1,2,3] but we feel the theory that lengthening of the costal cartilages during the growing period is the most plausible explanation[4] because we have failed to find evidence in our patients of any appreciable substernal ligamentous structure. There has been a familial history of the deformity in almost half of our patients. Varying degrees of pectus excavatum are seen and even though marked deformities are uncommon, the condition as a whole is not rare. The indications for operation are not always clear cut. It is not possible to predict which infant will develop a severe deformity, but it is best to correct them before irreversible postural, cardiovascular and pulmonary complications develop. Certainly the cosmetic indication is present but rarely should be the only reason for surgical treatment. Marked deformity will most often be accompanied by other symptoms, and operation should be advised to prevent compensatory kyphosis.

We perform[5], with minor variations, the operation of Ravitch.[4] The deformed costal cartilages are excised subperichondrally. Transverse wedge osteotomy of the sternum is performed and the corrected sternal position is held with interrupted wire

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Adapted from "Abnormalities of the Chest Wall" exhibit, International Medical Assembly, Interstate Postgraduate Medical Association of North America, in Pittsburgh, Pennsylvania, November 9-12, 1964.

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ABSTRACT—All too frequently, we misdiagnose and underestimate the full importance of abnormalities of the thoracic wall. There may also often be co-existent unrecognized entities carrying serious potentials and consequently delayed or poor selection of treatment occurs. A complete classification of these abnormalities is formulated, and the accompanying excerpts of cases amplify specific problems frequently encountered in the congenital, traumatic, infectious and neoplastic categories.

sutures at the osteotomy site. It is our belief that external fixation is unnecessary except in the rare adult instances requiring correction. All of our patients have shown permanent cosmetic benefit and the majority of preoperative symptoms were relieved when long-term follow-up was obtained.

**Pectus carinatum** (pigeon breast) has a convex sternal deformity resulting when the costal cartilages have grown in a direction opposite to that of a pectus excavatum. Usually it is nothing more than an asymptomatic anatomic curosity, excepting when there is continued trauma to the protuberance[5]. Other than a reverse transverse wedge osteotomy, the repair is similar to that for pectus excavatum.

**Partial ectopia cordis** with **bifid sternum** is due to a failure of union of two primitive cartilages from which the osseous sternum is formed. Our one experience with this entity[6] was the second successful repair known to have been performed by Sabiston's method.[7] It is noted that there is general agreement that whenever possible the preferred management should be direct operative closure in early infancy. Sabiston first reported a logical method of repair in older children. A triangular wedge of the connected xiphoid is excised. Two temporary sutures are placed around the sternal bodies. The first four costal cartilages bilaterally are exposed subperichondrally and obliquely incised. Sliding affords complete approximation of the bifid sternal bodies. We agree with Sabiston that there is no necessity for the use of grafts in such repairs.

**Thoracic outlet compression syndromes**[8] rarely occur early in life, but may have a congenital basis as the brachial plexus and subclavian vessels traverse a series of naturally occurring, narrow, rigid spaces in which only slight anatomic changes create compression or angulation. The specific etiology must be determined and is due to a great variety of entities, such as cervical rib, variations in the first rib, ligamentous attachments from the transverse process of the seventh cervical vertebra, etc. Acquired conditions may be the sole cause or may potentiate congenital variations: i.e., kyphosis, sagging shoulder girdle, aneurysm or poststenotic dilation of a subclavian vessel. Non-operative therapy may be indicated depending upon the etiology and response to treatment.

## *II. Infectious*

Rarely do infections primarily involve the thoracic wall in such a way as to cause abnormalities. However, when left untreated or if inadequately treated, significant deformities may occur secondarily which can greatly incapacitate or even result in death. Inadequate follow-up examination after initial care is often a cause. Resultant abnormalities include scoliosis, intercostal space narrow-

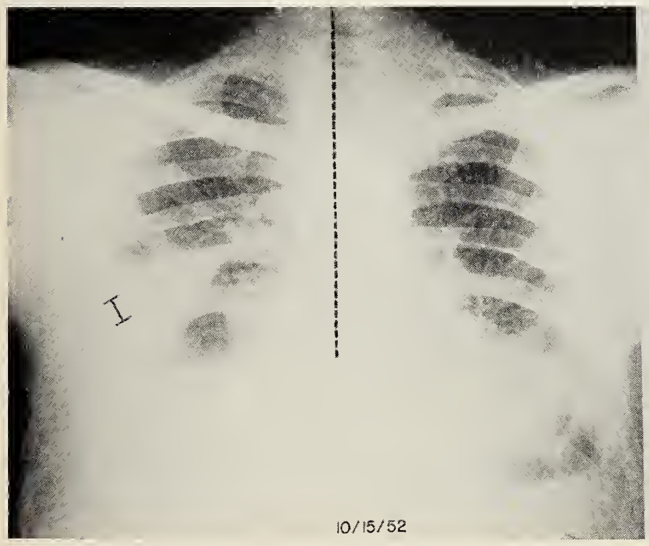

Fig. 1a. Onset of right pleural empyema from histoplasmosis. Note straight vertebral column and width of right intercostal spaces as marked.

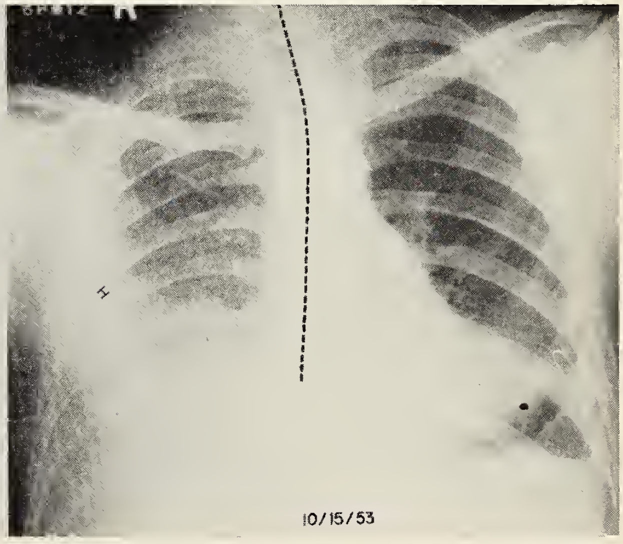

Fig. 1b. Retraction of fibrothorax one year later caused marked scoliosis and increased cardiorespiratory symptoms.

ing, osseous and soft tissue abscesses and sinuses. Infection may enter the thoracic wall through an open wound, by septicemia, or by direct extension of infections from within the thorax, abdomen, neck or axilla.

Figure 1a shows a patient in whom one year after pericardiectomy for constrictive pericarditis from histoplasmosis, a large right pleural effusion occurred. Since no attempt was made to remove it, the resultant fibrothorax caused a marked scoliosis (Fig. 1b) in only one year and increased cardiopulmonary symptoms. Nine years later, a decortication was performed and by the second postoperative day, scoliosis was entirely relieved. Had the empyema been diagnosed at its onset, adequate therapy initially would have obviated the need for extensive and difficult decortication.

A frequent cause of costochondritis is from leaving behind a denuded rib or costal cartilage after a subperiosteal rib resection. Infrequently tuberculosis may be a cause (Fig. 2) and without total excision of the involved structure as Ballinger reemphasizes, a high recurrence rate ensues. Whenever the second rib is involved by idiopathic costochondritis (Tietze's syndrome), excision to exclude malignancy is indicated only when symptoms and signs persist beyond one month.

Thrombophlebitis of the thoracoepigastric vein[10] (Mondor's disease) resolves without treatment by three months and should not be confused with metastatic malignancy.

## III. Traumatic

Trauma may cause thoracic wall abnormalities early or late. Unless an obvious deformity occurs initially, such as an open sucking wound, the major problems are overlooked easily. Without proper investigation, serious threats to life occur insidiously, especially when follow-up is inadequate. The dangers are tension pneumothorax, hemothorax, empyema, sinus tracts, abscesses, myocardial damage, aortic false aneurysms, ruptured diaphragm and intra-abdominal injuries. Even without suggestive physical findings, one must consider all these possibilities.

The severely traumatized victim needs thorough and repeat physical examinations, initial and follow-up diagnostic studies, intensive care ward observation, and the physician "team approach" under a "captain," preferably a general and thoracic surgeon. We must remind ourselves of all potentials of injury. Shefts[11] repeatedly reiterates in his monograph the value of frequent personal observation of all factors capable of deranging cardiopulmonary physiology. It must be emphasized that potential danger persists beyond the first few hours after injury, with a latent period extending into days, months and even years!

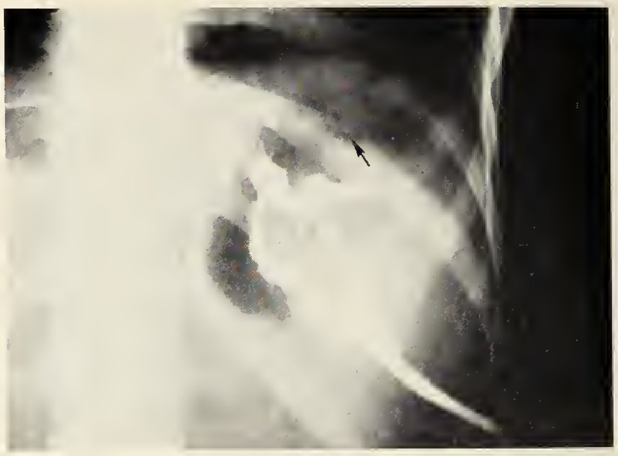

Fig. 2. 1 mo. after limited resection of 11th left rib for tuberculous ostolytic lesion, drainage from wound started and persisted for seven months. Anti-tuberculous drugs initially were given for only two months. Sinogram outlines the parietal abcess. Had laminography not been done, destruction in adjacent rib (arrow) would have been overlooked at operation (complete two rib resection was performed). Wound was packed open. Chemotherapy given for one year; no recurrence noted in three years.

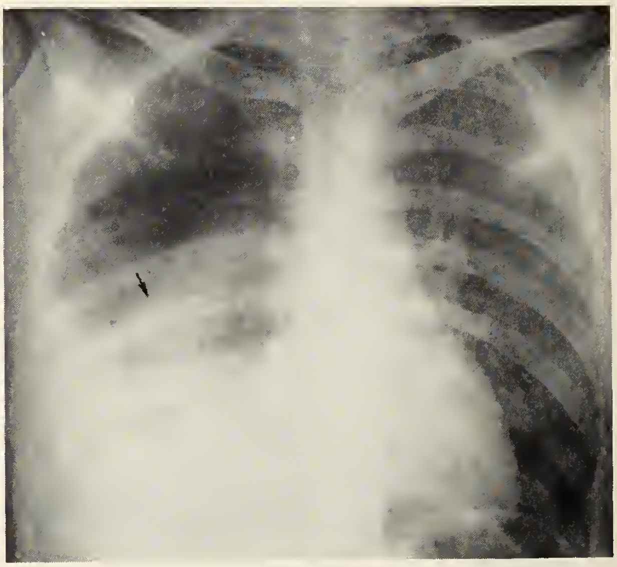

Fig. 3. 19-year-old male with no obvious cardiopulmonary compromise despite this tension pneumothorax from one fractured rib. Arrow depicts the markedly collapsed lung just above a hemothorax. *Three days later* on transfer to us, he suddenly became cyanotic, dyspneic and hypotensive. Immediate intercostal catheter drainage completely re-expanded lung.

**Closed blunt trauma** may cause rib fractures that are more than a painful nuisance, e.g., the tension pneumothorax from just one fractured rib (Fig. 3). By encasing vital organs, the intact thoracic cage serves as a "guardian of life" but when merely its ribs are fractured, the ribs may become instruments of death.[12] A patient, kicked in his ribs, did not have a chest x-ray examination during an emer-

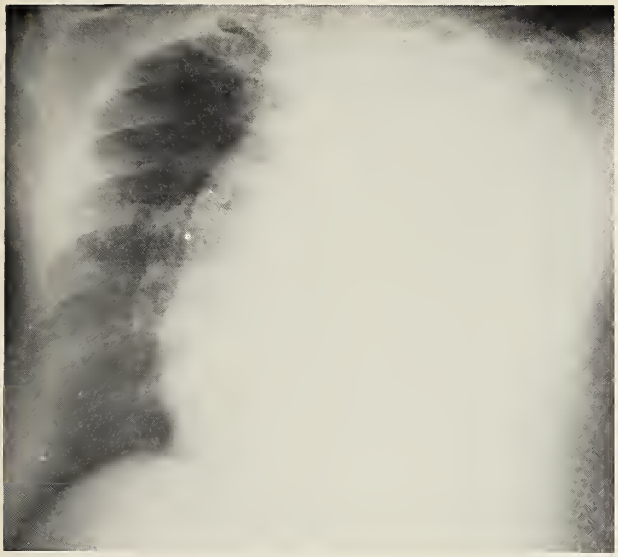

Fig. 4. Massive hemothorax (5000 cc.) *over nine days* from one bleeding intercostal artery and fractured ribs from blunt closed trauma causing only pain initially. He returned to hospital complaining of weakness and dyspnea. Note mediastinal shift to right.

gency room visit nor was further follow-up advised. He was suddenly hospitalized nine days later (Fig. 4), and emergency thoracotomy was required to control active hemorrhage from one intercostal artery which caused a 5000 cc. hemothorax. Blunt trauma to the left upper quadrant in another patient caused enough pain to make him splint his respiratory movements. Consequently a massive left atelectasis from retained secretions developed ten days later (Fig. 5a and b). This was easily relieved by nasotracheal suctioning. The extremely latent dangers of aortic trauma are demonstrated in Fig. 6, where a false aneurysm is shown seven years after blunt trauma with no obvious sequelae at the time of injury when no chest x-ray examinations were advised.

The majority of lung herniations are associated with thoracic trauma. Some occur in people with occupations requiring forced expiratory movements with a closed glottis. Usually they are of no great consequence, but when surgical repair is required, all pulmonary infection should be cleared for at least six months. Any type of surgery in the lower cervical areas may easily create dangerous, intra-

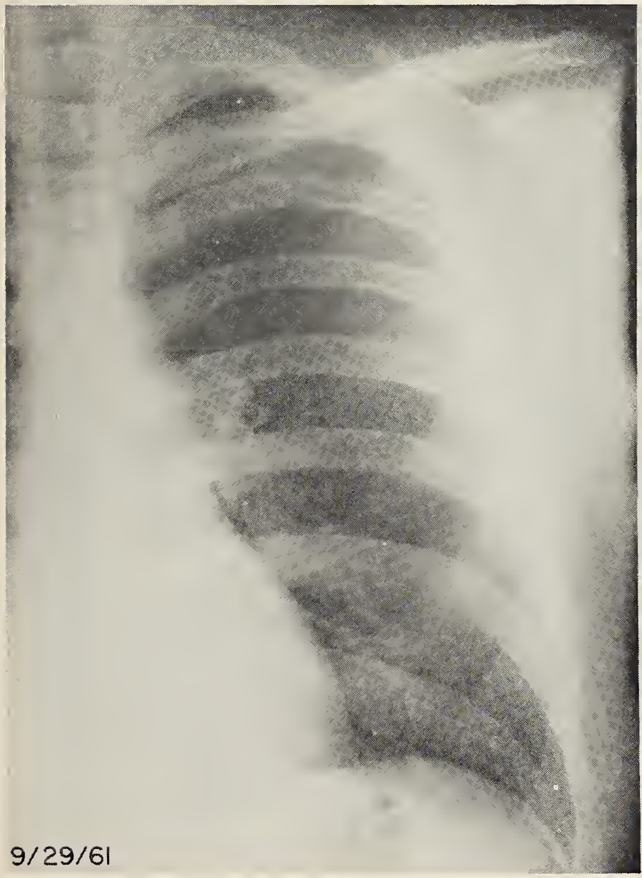

Fig. 5a. Normal chest x-ray when admitted for fractured right tibia and blunt closed trauma to rib cage over left upper abdominal quadrant.

Fig. 5b. Latency emphasized: *ten days* later marked atelectasis—retained secretions by patient's limiting his respiration and coughing because of pain.

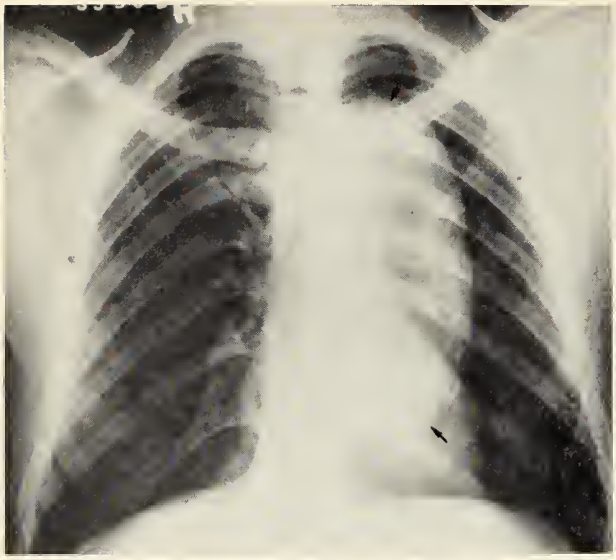

Fig. 6. False aneurysm (arrows) arising typically just distal to left subclavian artery's origin from thoracic aorta. Steering wheel injury *seven years ago*. Because of no complaints and no obvious signs of external injury, examining physician took no x-rays and did not advise any follow-up investigation.

thoracic sequelae if there is also a pulmonary hernia in the neck (Fig. 7).

In the patient shown in Figure 8, **open trauma** from thermal injury resulted in non-healing[9] of only one small area on the right hemithorax two years following grafting for 40 per cent burns of the abdomen, thorax, arms and face. Laminography alone demonstrated the extensive cavitation in the underlying rib. It was not until the third and much more extensive resection of the affected rib that healing occurred.

## *IV. Neoplastic*

Since thoracic cutaneous and subcutaneous neoplasms require the same therapy as in other areas of the body, all of the following relates to tumors in the deeper thoracic parietes. The dictum "long standing disease excludes malignancy" could not be more inaccurate when pertaining to thoracic wall neoplasms. Certain benign lesions undergo sarcomatous degeneration and even malignant tumors have been reported to stay localized for periods as long as ten years.[13]

Keeping in mind the third dimension, multiple view roentgenograms and laminography of the thorax permit better evaluation for the presence, locale and extent of parietal tumors. A diagnostic pneumothorax may be of great value, especially in instances of unexplained pleural effusion or thoracic pain. This procedure also helps determine if the underlying lung and pleura are involved.

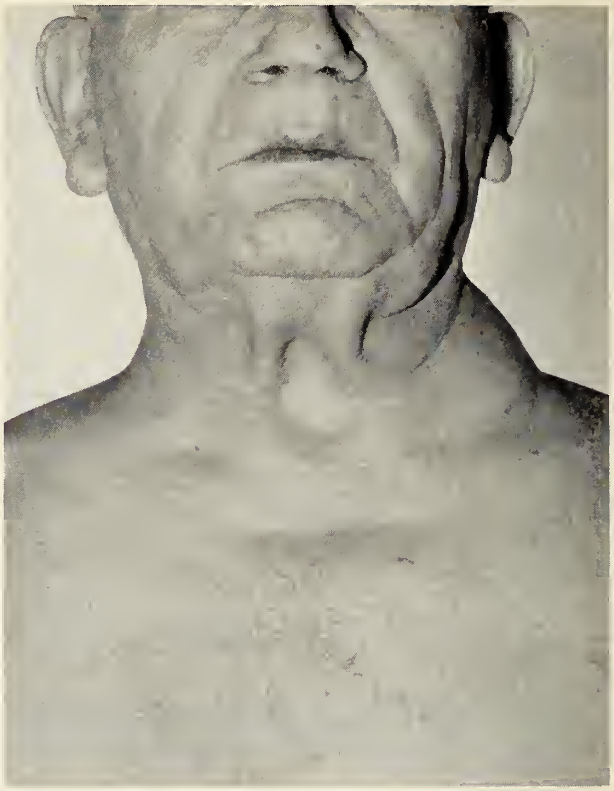

Fig. 7. Left cervical hernia of lung very obvious during inspiration. Excision of his overlying lipoma was dangerous: i.e., pulmonary injury, pneumothorax, etc.

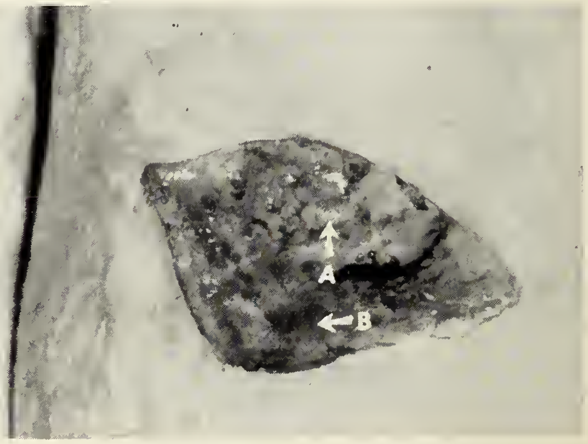

Fig. 8. Non-healing illustrated by purulent exudate and sinus tract at (A) persisted *two years*. Etiology: underlying costal osteomyelitis with abcess visible only by laminography. When disease finally excised completely, healthy granulation tissue (B) completely covered wound and healing ensued.

Limited biopsies (needle and wedge) are misleading histologically and could implant neoplastic cells elsewhere. All tumors of the deep thoracic wall should be considered malignant[13,14] and excised completely without biopsy. Actual diagnosis by total excisional biopsy and frozen section microscopy should be established only when the surgeon can continue with the correct and more extensive resection.[15]

### A. Primary, benign

The innocent lipoma may imitate an iceberg and extend deeply, even below the parietal muscles or into the mediastinum and spinal column.[9,13,14] Lipomata in the thoracic wall may be fixed or move slightly. Such lesions cannot be approached safely under local anesthesia.

The ganglioneuroma demonstrated in Figure 9 emphasizes the need for adequate roentgenographic evaluation because its large opacity was missed at re-enlistment examination for the Navy. The need for multiple views is emphasized as it was best seen in the right anterior oblique view, poorly in the posteroanterior and not at all in the lateral projection. Without excision, malignancy could not be excluded. These neurilemmomata rarely become malignant, but 18 per cent of neurofibromata show malignant change.[9]

During preoperative evaluation for an inguinal herniorrhaphy, the costal osteochondroma shown in Figure 10 was discovered. Not realizing its malignant potential, the patient was first advised that it was not important. A diagnostic pneumothorax demonstrated that the lung was not involved.

### B. Primary, malignant

Fibrosarcoma is the most frequent of the primary soft tissue malignancies of the thoracic wall.[15] If resection is incomplete, this lesion becomes more anaplastic and spreads widely. Because it spreads along fascial planes and can be multicentric, excision must be wide enough to include the entire muscle group that is involved.

Five years after a "lump" was first observed in the lower left hemithorax, a 20 × 14 × 11 cm. mass was excised with only a 5 cm. margin of uninvolved rib. Subsequently six years later, at another resection, a 35 × 25 × 20 cm. tumor was excised with additional tumor left behind. By another three years (14 years after the onset), when first seen at our hospital, these immense proportions had been attained (Fig. 11). Initially called a chondroma, the diagnosis of the first specimen was later revised to low grade chondrosarcoma. Implantation and/or incomplete resection originally initiated this tragic sequence of events. Longevity and difficulty in correct pathological interpretation are also depicted which are not unusual with chondrosarcoma.[13]

### C. Secondary

The subdivisions of this category, metastatic, implanted, and contiguous, are self-explanatory. Because metastatic neoplasms are far more frequent in the thoracic parietes than primary ones, a search for the original tumor, including a skeletal survey, should be performed for all thoracic parietal tumors. Not infrequently, secondary lesions prompt the initial investigation, and it is not until

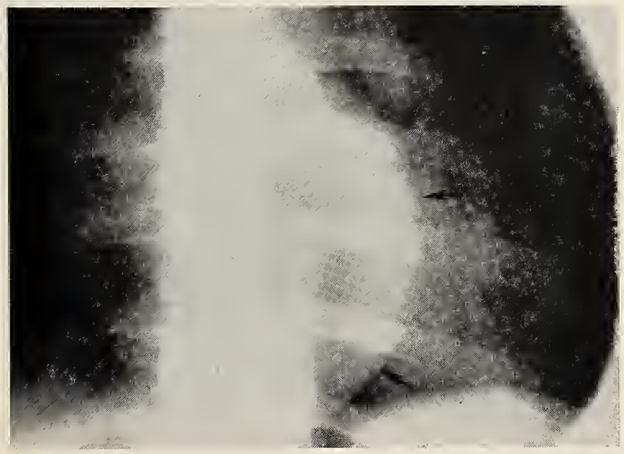

Fig. 9. Retropleural benign ganglioneuroma (neurilemmoma) of sympathetic chain and intercostal nerves. Easily seen in this PA spot film, and also in right anterior oblique projection. Overlying cardiac density makes visualization difficult on routine chest x-ray.

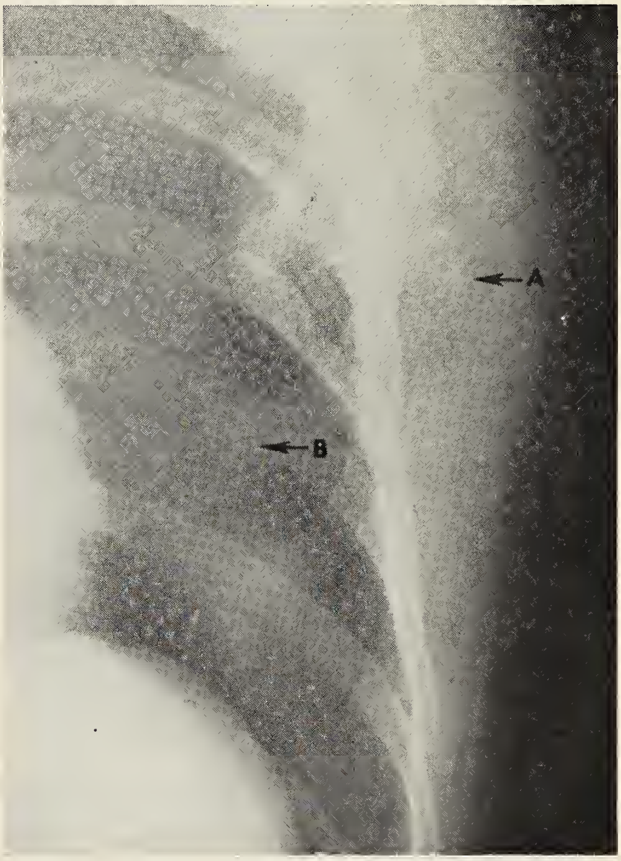

Fig. 10. Costal osteochondroma bulged into parietal muscles at (A). Diagnostic pneumothorax, reveals lung (B) to be free of tumor. Biopsy specimen for frozen section consisted of entire involved rib and segments of adjacent uninvolved ribs, muscles and pleura. As benign, no further resection was required.

later that the primary tumor is discovered. The commonest sites for primary malignancies that metastasize most often to the thoracic cage are thyroid, kidney, and lung.[9]

**Metastatic:** Because of the chief complaint of tenderness in the left thoracic wall, an osteolytic costal lesion was excised totally. As a result of metastatic bronchogenic carcinoma reported on frozen section, a more radical excision was contraindicated. The standard thoracic roentgenogram did not reveal the primary tumor that was later found in the right lower lobe at bronchoscopy.

**Implanted:** Every attempt should be made to avoid contaminating an incision with neoplastic cells. Such is illustrated by the patient in Figure 12 who had a pneumonectomy two and one-half years earlier and returned with this fungating mass in his incisional scar. Laminography revealed that the bulk of the tumor extended only 3 cm. below the skin surface. The patient refused an excision and

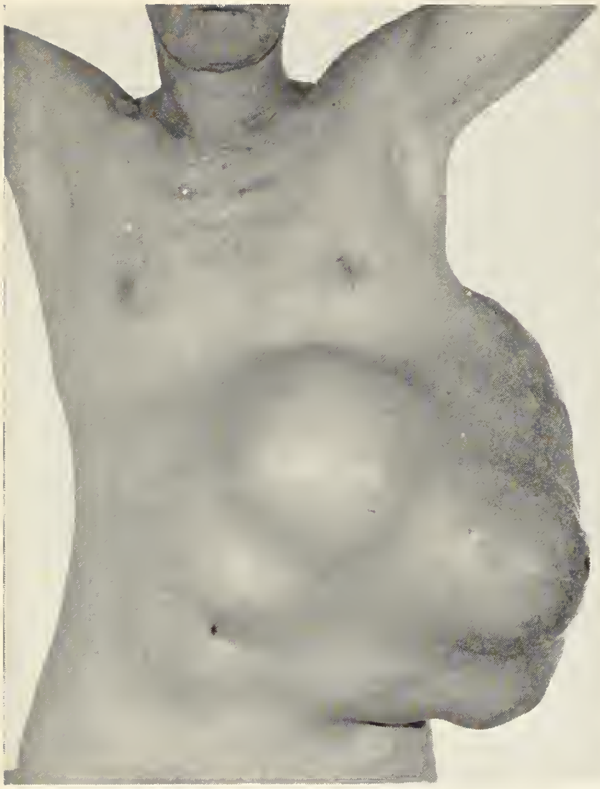

Fig. 11. Result of inadequate therapy initially. Low grade chondrosarcoma 14 years after discovery. Called chondroma at initial limited resection nine years ago. No curative therapy possible now.

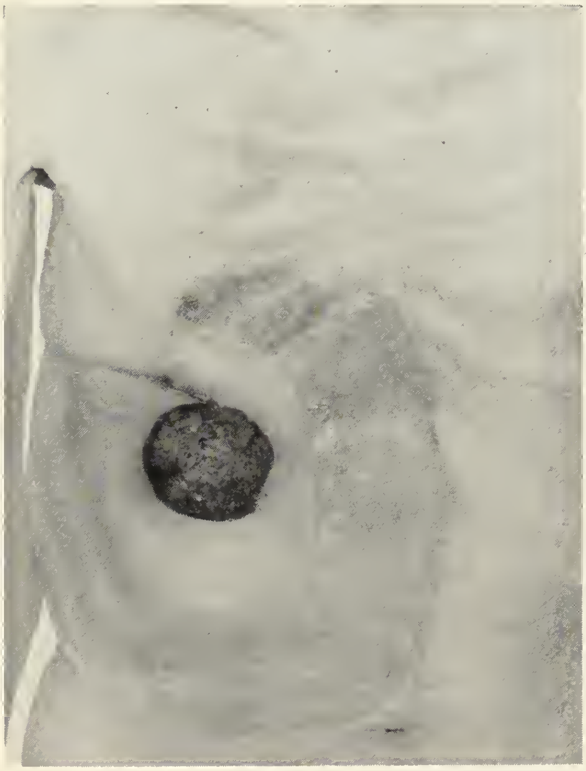

Fig. 12. Following pneumonectomy for bronchogenic carcinoma, incisional implantation of tumor cells became apparent 2½ *yrs. later.*

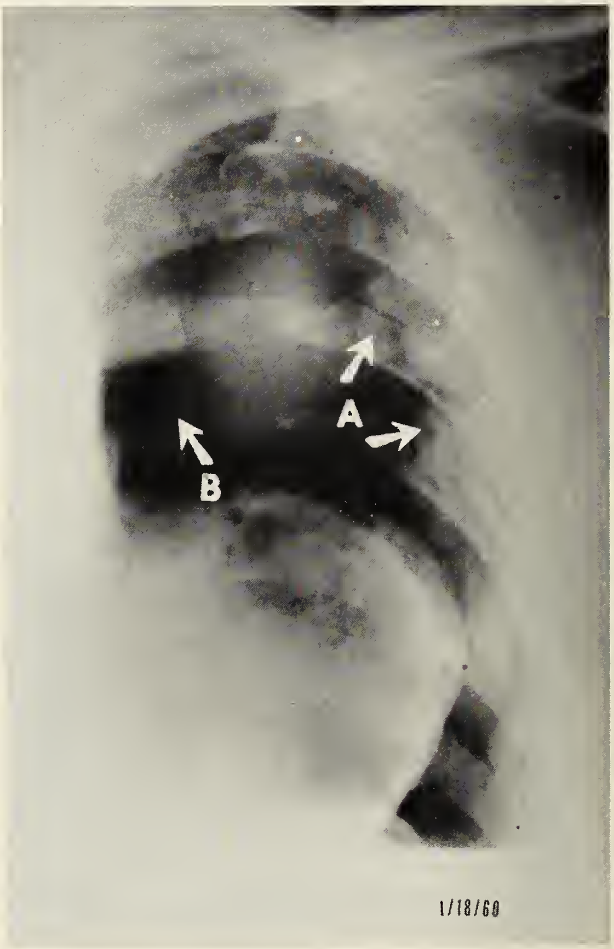

Fig. 13. Parietal pleural mottling (A) by diffuse, malignant mesothelioma compared with uninvolved pleura (B). Tumor seen *only* if pneumothorax present; recognized only when pneumothorax occurred. Nine months' history of thoracic pain and frequent recurrences of massive bloody pleural effusion.

following irradiation the mass decreased in size. At the first sign of a recurrence of any thoracic wall tumor, a wide excision is indicated.[13,15]

**Contiguous:** It should not be forgotten that bronchogenic, mediastinal, and spinal cord tumors extend directly into the thoracic wall. The comparatively rare pleural mesothelioma, may similarly involve the thoracic wall as was the situation in the patient in Figure 13. Of many films, the first roentgenogram to reveal this lesion in a period of nine months was one showing a spontaneous pneumothorax.[16] This certainly proves the diagnostic value of intrapleural air. Although not present in this patient, physical findings suggestive of thoracic wall involvement are bulging, and hard intercostal spaces plus an increased resistance to thoracic compression or to passage of needles for thoracentesis.[17]

## *Summary*

1. A complete classification of all thoracic wall abnormalities has been formulated which is useful clinically.

2. Because of the tendency to underestimate the importance of these abnormalities, it follows that there may be simultaneously unrecognized entities with serious potentials and inadequate therapy applied.

3. Excerpts from cases are presented to amplify specific problems frequently encountered.

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### Emotional Factors in Headache

*(Continued from Page 401)*

satisfaction can be found. The emotional problem may not seem particularly serious to us but it must be interpreted in the patient's frame of reference.

* * *

IN SUMMARY, THE MOST common source of headache is an emotional problem or stress. Although in many instances this may not be severe enough to bring the patient to the physician, it may very well be a significant factor in the overall problem which does bring the patient to the physician. It is important, therefore, to identify the psychological factors as well as the physiological, since the physiologically determined headache may be aggravated by emotional stresses.

Finally, it should be recognized that headache is frequently a manifestation of an underlying and hidden depression.

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It costs the pharmaceutical industry an average of $36,000, with some companies spending as much as $75,000 a year in laboratories, equipment, salary, and overhead, to keep just one research scientist on the job and provide him with proper technical assistance and equipment. A National Institutes of Health analysis of pharmaceutical industry research and development provides a more sharply focused comparison, showing expenditures of $76,500 per doctoral-level research scientist.

With the marked increase in life expectancy the medical profession is faced with an entirely new subspecialty—the prevention and treatment of that chronic and incapacitating deficiency disease, the menopause. Fortunately the availability of estrogens and progesterones of proven efficacy and safety provide the therapeutic tools to make what has become almost half of a woman's life, comfortable, healthy, and productive.

# THE MENOPAUSE

## A DEFICIENCY DISEASE

**By F. P. Rhoades, M.D.**
**Detroit, Michigan**

At the beginning of the Christian era, life expectancy was less than 25 years. By the fourteenth century, it had increased to a little over 30 years, but was still under 50 years as recently as 1900.[1] Thus, it is only during the last half century that women have lived long enough to make the medical profession generally aware of the multiple problems presented by the menopause.

Advances in sanitation, immunization against childhood diseases, better housing, an abundant food supply, and widespread availability of good medical care have all combined to bring about this marked increase in life expectancy.

A boy born today can look forward to approximately 70 years of life, while a girl can expect to live to be almost 80.

It is estimated that by 1975 there will be 40 per cent more women than men in the United States.[2]

* * *

THEREFORE, the medical profession is faced with an entirely new subspecialty: the prevention and treatment of that chronic and incapacitating deficiency disease, the menopause.

While men do not live as long as the so-called weaker sex, neither do they suffer a rather sudden catastrophic change such as women do. The male experiences only a gradual decline in his gonadal output of hormones, and thus he remains essentially a man until his death. With the woman the situation is entirely different. Her ovaries become inadequate relatively early in life, usually in the fifth decade. The human female is the only mammal that lives beyond her ability to reproduce.

In the natural course of events, the average woman may expect to enter the menopause sometime during her forties. A generation ago this event, with all its side effects, had to be accepted passively. At that time means for simple and effective treatment had not been found.

Today such means are readily available. It is similar to what happened with diabetes after insulin was discovered in the 1920's.

* * *

BEFORE DISCUSSING methods of treatment, however, I should like to consider what happens to women at the time of the menopause in terms of some of the physical, mental, and emotional changes they may undergo.

The key physical change, of course, is permanent and irreversible atrophy of the ovaries. These organs, which formerly produced one or more ova at monthly intervals, as well as hormones, now shrink to small fibrous nubbins. Functionally, castration takes place.[3-6] And this occurs at a time when there are two, three, or more decades of life remaining.

What are the prospects without treatment that these will be healthy, comfortable years?

The loss of the ova-producing capacity causes no known ill effects. On the contrary, being sterile now protects older women from the stresses of pregnancy for which they may no longer be physically fit. But the loss of the female sex hormones, the estrogens and progesterones, is quite another matter.

* * *

ESTROGENS ESPECIALLY, are needed for the cells of the body to function at their best. They are intimately concerned with cellular metabolism; they promote improvement in cell permeability, and are an important factor in the regulation of electrolytes and water balance. When estrogens are in short supply there is a tendency for more nitrogen to be excreted than is absorbed—this produces a negative nitrogen balance. This unfavorable balance leads to a marked loss of muscular strength, especially of the voluntary ones. In time, many muscle cells are replaced by fibrous tissue resulting in stiffening of both muscles and ligaments. Long continued weakness and wasting of the muscles occur.

Changes in the skeleton are also observed. In the spine, the "dowager's hump" (dorsal kyphosis) often is seen, and there may be a loss in body height of from one to five inches. Low backache is also a frequent symptom. Further, the "thinned" long bones become fragile and liable to be broken and structures in and around the joints tend to atrophy with arthritis. Osteoblastic cells are dependent upon estrogen, hence the more estrogen present the greater the osteoblastic activity. Osteoclasts which are not affected by estrogen continue their destructive activity, so it is most important that sufficient estrogen be present to stimulate osteoblastic activity and to prevent osteoporosis from developing. This picture can be relieved in almost all cases in a matter of weeks with large doses of estrogen.

* * *

ANOTHER WELL-KNOWN accompaniment of estrogen deficiency is atrophy of the skin. Lack of estrogen causes the skin to become dry, scaly, inelastic and tough. Keratinization is often abnormal. Pruritus is frequent. Estrogen therapy reverses this picture since it improves tissue hydration, blood circulation, and restores skin elasticity.

In the absence of estrogen the breasts become flabby, wrinkled, and atrophic. The nipples flatten out and become nonerectile. Both estrogen and a progestogen are needed to correct these changes in the breasts.

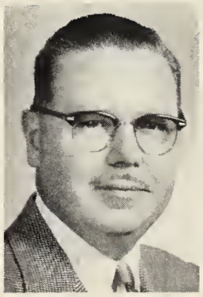
Marked changes occur in the genitalia. Fat is reabsorbed from the vulva and pubic area, the labia almost cease to exist. Pubic and axillary hair become scanty. The uterus atrophies to prepubertal size, the tubes become thread-like, and the ovaries small and rock-like. The vagina shortens, loses its distensibility and its mucosa becomes thin and friable, presenting the picture of senile vaginitis. The vaginal mucosa, because it is friable, becomes susceptible to infection and vaginitis. Adequate hormone therapy can completely reverse these dismal developments, with the exception of the ovarian atrophy.

In addition to these, less obvious functional changes may occur in blood vessels and blood pressure. Before the menopause, for example, women are between 10 and 40 times less likely to have coronary arteriosclerosis than are men of the same age. This favored status is gradually lost as estrogen levels decline. Similarly, high blood pressure is more common in young men than young women; after 40 the reverse is true. The cholesterol level falls when the estrogen level rises, and increases when the estrogen level falls. Estrogen even when given to men can lower the cholesterol level, although at the price of feminization which most men are unwilling to accept.

* * *

IT WOULD BE surprising indeed if these profound physical changes were not attended by mental and emotional alterations. In fact, depression, anxiety, and involutional melancholia may occur and many women who escape these develop a "vapid, cow-like 'negative state' in which the world appears as through a gray veil,"[4] leading to permanent negativism. Estrogen administration in the majority of both mild and moderately severe cases causes improvement in a very short time.

Altogether, these physical and mental changes add up to a singularly unattractive future for women 40 years of age and over. Their cause—hormone deficiency—is known. Orally active medications are available which have been demonstrated to be both safe and efficacious. Substitution therapy is freely given at all ages in diabetes, hypothyroidism, and adrenal deficiencies. It is just as logical and proper to give hormone therapy to postmeno-



The Author

**F. P. RHOADES, M.D.**

pausal, hypogonadal women regardless of age. Potent and reliable conjugated equine oral estrogens such as (Premarin) can now be used with even greater safety since effective oral progestogens such as Provera are on the market.

For the premenopausal woman who still menstruates regularly but is estrogen-deficient, as determined by the vaginal cytogram,[8] an estrogen should be given during the first 21 days of the cycle.

If menstruation is irregular a progestogen such as medroxyprogesterone acetate (Provera) or norethynodrel (Enovid) is given from day 14 to day 25, in addition to the estrogen.

* * *

IN THE POSTMENOPAUSAL woman the combined treatment is also used. The progestogen, of course, will re-establish uterine bleeding. This is desirable in order to prevent undue endometrial hyperplasia. It in effect produces a medical curettage.

At one time, some investigators held the opinion that estrogens might cause genital cancer but continuing experience today suggests that cancer develops less frequently in women given adequate hormone replacement than in those who are untreated. In five separate studies involving 1,422 women who were given estrogens, some for as long as 25 years, only five cancers occurred. The number expected was 96.[2] This is convincing evidence that estrogens, instead of causing, may in fact prevent cancer. After all, these agents are physiologically active agents normally present for 25 years or so in premenopausal women.

* * *

THE DEAD HAND OF tradition has acted to prevent many physicians from actively treating the menopausal woman.

There is a deep philosophic reluctance to interfere with what is regarded as the inevitable process of aging. Undue fear of breast and genital cancer is in the minds of many physicians. Other reasons given are the expense and inconvenience entailed by the long continued treatment needed. Undesirable side effects, such as uterine bleeding, breast tenderness, nausea and gastrointestinal upset, and pelvic congestion are cited as deterrents to the long continued use of the hormones.

All of these objections are readily overcome with adequate education of the patient in the proper use of the hormones.[2-7]

There are thus many pressing reasons for the life-long replacement treatment of the menopausal woman with the female hormones. One need only point out the population explosion of postmenopausal women. There is increasing evidence that cancer is prevented, not caused, by adequate hormone therapy. The availability of potent oral progestins has markedly increased safety.

Lastly, there is a growing realization that it is both morally and medically justifiable to make what has become almost half of a woman's life comfortable, healthy, and productive.

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**Serous otitis media is a very common affliction, and is usually secondary to transient Eustachian tube inflammation. However, there are other more serious causes of this sign. The nose and nasopharynx should be examined in each case, particularly in adults with a unilateral serous effusion of long standing. X-ray examination is sometime of great help in diagnosis.**

# SEROUS OTITIS MEDIA

## THE NEED FOR ITS RECOGNITION AS A SIGN RATHER THAN A DIAGNOSIS

**By Ward B. Litton, M.D.***
**Of Ann Arbor**

In the shift from aquatic to terrestial life, the organ of hearing underwent remarkable evolution. A means for overcoming the mechanical disadvantage of sound energy transfer from the air surrounding the external ear to the liquids bathing the inner ear developed phylogenitically. This device is the middle ear.

Equal air pressures on the two sides of the vibrating tympanic membrane are called for in the design. The Eustachian tube, which serves the function of allowing ingress of air to the membrane's inner side, was unfortunately placed so that it is subject to all the ills of the nose, paranasal sinuses and upper throat.

Serous fluid virtually never arises in the middle ear spontaneously. It is usually the result of disease, rather than a disease, and should therefore be considered a sign rather than a diagnosis. If so considered, the physician is more likely to exert proper effort to establish the cause and treat it, rather than direct treatment solely to the effusion.

There is an understandable tendency to diagnose and treat only the chief complaint of hearing loss and stuffiness of the ear and to overlook local or adjacent serious primary disease.

Serous otitis media is most frequently a result of altered function of the Eustachian tube. Its length, anatomical configuration, proximity to respiratory organs and peculiarities of physiology, all figure in the variety of conditions which can alter its function. A consideration of its normal function is helpful to understanding its response to disease.

The Eustachian tube (or pharyngotympanic tube) is cartilaginous in its medial portion. This part is normally collapsed so that mucosal walls are apposed. Opening occurs by muscular effort of the tensor veli palatini and levator veli palatini. Yawning and swallowing are examples of normal pharyngeal movements causing opening of the tube with consequent periodic equalization of middle and external ear pressures.

Air can passively escape from the middle ear because of the flutter valve-like construction of the tube. This first occurs when the middle ear air pressure exceeds that in the nasopharynx by about 15 mm. of Hg. An example would be ascent of about 500 feet in an airplane. Subsequently, air will passively escape at lower pressure differentials if they occur in rapid succession (about 11 mm. Hg.).

Earth bound physiology calls for constant replenishing of air to the middle ear since the air therein is continuously absorbed by its mucosal vessels. This requires active opening of the Eustachian tube. If this normal function is prevented by edema and vascular engorgement of the tube (for example by

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an acute nasopharyngitis) or by an extrinsic tumor mass (such as a large antrochoanal nasal polyp) the middle ear vessels will continue to absorb oxygen. The tympanic membrane will be drawn inward and serous fluid will finally escape through capillary walls into the middle ear. A yellow, retracted membrane results as well as a mild conductive hearing loss with its attendant symptoms. This describes events in mild barotrauma to the ear when middle ear air pressures are reduced over those in the external ear and nasopharynx.

Fluid accumulation in the middle ear is very common, particularly in children. Infection and hypertrophy of the adenoids with resultant Eustachian tube obstruction is the most common cause of deafness in this age group. Frequently the slight resultant hearing loss is unnoticed by the parents, and many otologists suspect the vast majority of cases are never seen. Routine testing in the grade schools confirms this suspicion; about 2 per cent of all those tested have the diagnosis of serous otitis media.

On the other hand, unilateral fluid in the middle ear, particularly in adults, should raise the danger flag before the physician's eyes, as the following cases testify:

## Case Summaries

L.S. was first seen on 7/30/53, at the age of seven years. She had a three-year history of decreased hearing in the left ear. She had had a tonsillectomy and adenoidectomy and myringotomy AS with transient hearing improvement. Examination revealed a yellow retracted tympanic membrane AS. The nose and nasopharynx were clear. From this time until 8/26/63, six operations were performed in an attempt to aerate the middle ear. Polyethylene tubes were placed through the tympanic membrane twice. One was placed through the Eustachian tube by the transtympanic route. All were extruded with resultant fluid re-accumulations. Finally, an extra-myringeal tube remained *in situ* for three months, and when finally spontaneously extruded, an air containing tympanum was noted. This case illustrates stenosis of the Eustachian tube by inflammatory disease; extreme difficulty is encountered in treating these cases.

M.F., a 39-year-old housewife, complained of fluid in the right ear for eight years and episodic lightheadedness for five months. Eight years prior, a myringotomy was done on the right ear because of the fluid accumulation, and two more myringotomies were performed shortly thereafter, because of recurrence. In the past four years she was seen repeatedly for this problem and a further eight myringotomies performed. Examination revealed yellow serous fluid behind a retracted right ear drum. A mild conductive hearing loss was present. On mirror examination of the nasopharynx, there was a suspicious submucosal fullness above the right Eustachian tube orifice. X-rays (Fig. 1) revealed a lytic lesion at the base of the skull. Biopsy showed a pseudoadenomatous basal cell carcinoma of the nasopharynx. X-ray therapy was given December 1958—January 1959, with a tumor dose of 6112 r given through two lateral fields. Follow-up skull films of August 1960 showed some reconsitution of bone at the site of previous neoplastic lysis. There is no evidence of recurrence to date.

L.M., a 47-year-old male, presented following extensive medical investigation of bitemporal headaches and bilateral ear infections. Two myringotomies in each ear because of persistent fluid in the ear had been performed over the past three months. Further questioning of relatives revealed excessive fatigue and personality changes in the patient of about one year's duration. Outside x-rays showed a lesion, prompting consultation.

Examination showed an apathetic listless male whose nasopharygeal vault was bulging, obliterating both Eustachian tube orifices. There was fluid in both middle ears. Skull x-rays (Fig. 2) showed spenoid sinus opacity and expansion with destruction of the sella. Laboratory data revealed evidence

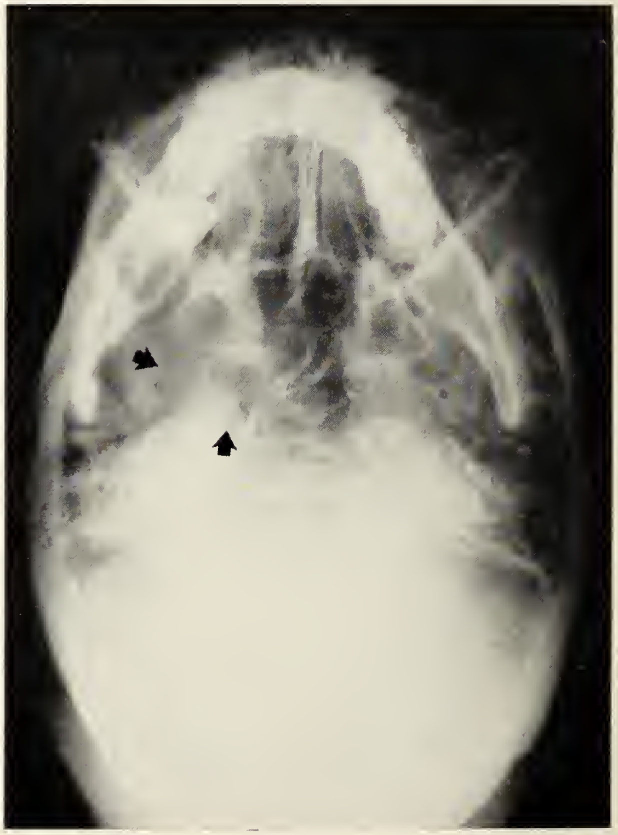

Figure 1.

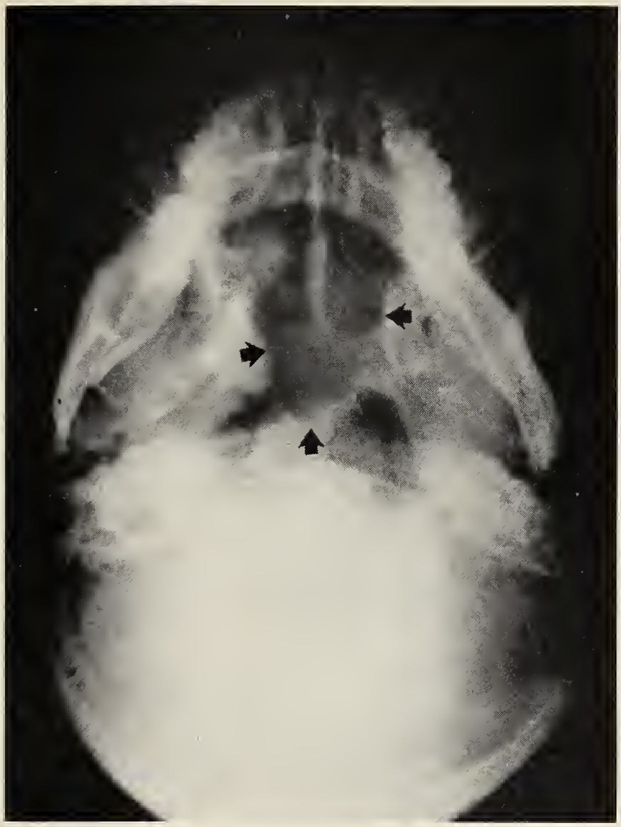

Figure 2a.

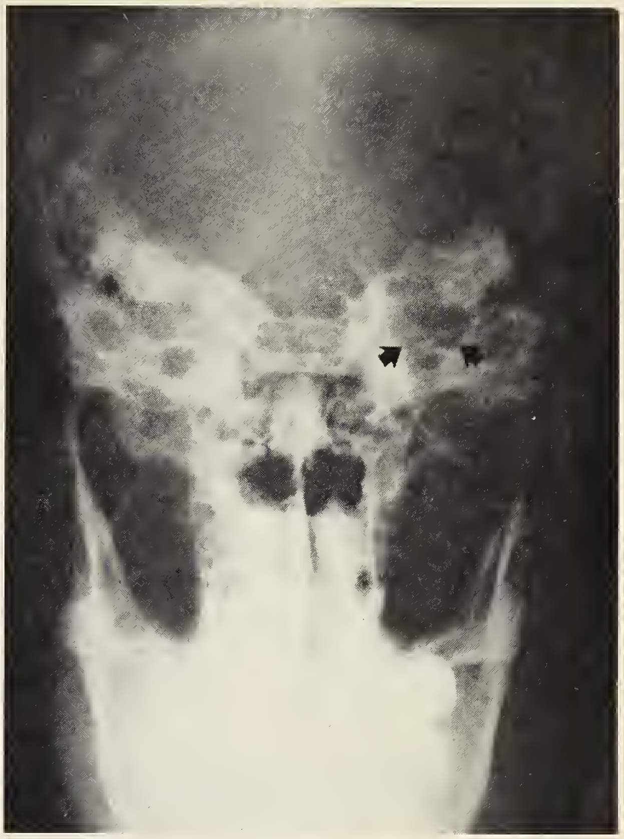

Figure 3a.

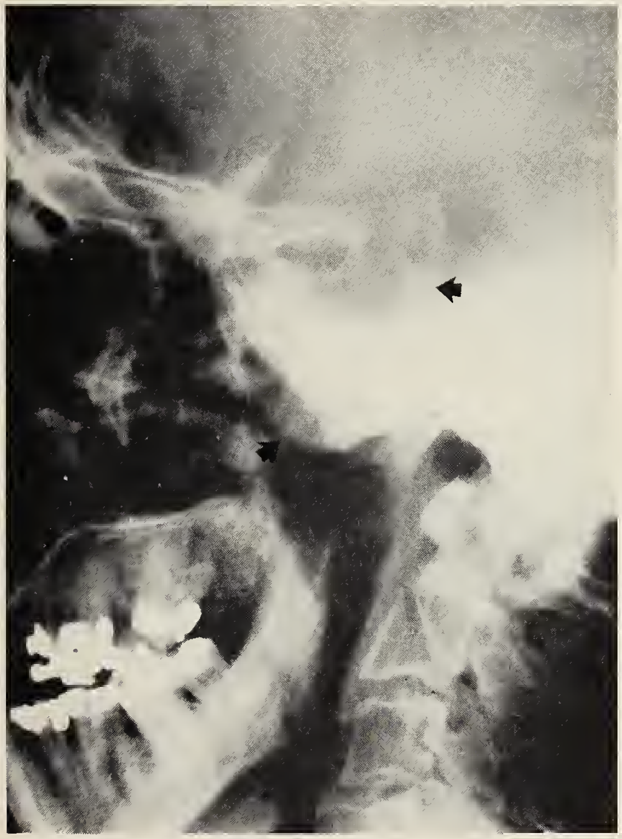

Figure 2b.

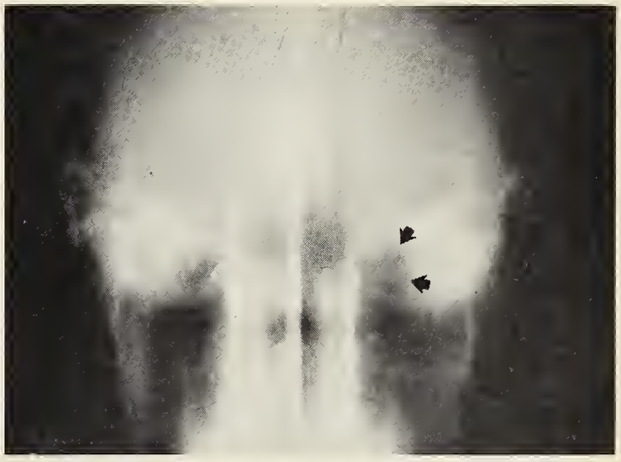

Figure 3b.

of panhypopituitarism: Na 118 mgm. per cent, K 5.0 mgm. per cent, Cl 84 and $Co_2$ 25 milliequivalents per liter, Ca 9.0, Phosphorus 4.2, and FBS 57 mgm. per cent, 17 ketosteroids 4.8 and 17 OH steroids 1.4 mgm. per 24 hours, $I^{131}$ uptake 7.9 per cent (normal 10.5-38.9%).

After suitable adrenal steroid preparation of the patient, a sphenoidotomy was done on 3/25/64. A sphenoid mucocoele was found and verified by histologic examination. Exteriorization via the nasal septal approach was accomplished, with recovery ensuing. Pituitary function did not return to normal after decompression; replacement therapy with adrenal steroids, thyroid hormone and testosterone has been continued.

V.B., is a 35-year-old male who had noted decreasing hearing in the left ear for one year. There was throbbing tinnitus with intermittent gurgling and crackling in the involved ear. Two months ago a myringotomy was done with profuse bleeding resulting. Another myringtomy for installation of a polyethylene tube was abandoned because of bleeding. Examination revealed a reddish mass in the posteroinferior quadrant behind the left tympanic membrane. The tympanic membrane pulsated with increased pressure in the external canal which pressed the tympanic membrane against the mass. There was a mild conductive hearing loss. X-rays (Fig. 3) including laminograms in the AP projection showed massive destruction of the left petrous bone with extension of destruction into the posterior fossa. A biopsy done through a transtympanic exposure showed a chemodectoma of glomus jugulare origin. X-ray therapy was given because of the size and inaccessibility of this "benign" lesion.

## Summary

The finding of a serous effusion in the middle ear immediately alerts the examiner to the need for a complete history and ear, nose and throat examination. Infection of the nasopharynx or paranasal sinuses, neoplasms of the middle ear, nose and nasopharynx, both benign or malignant, are possible causes. Next to the history and physical examination, x-ray examination of the skull, particularly with base views, is most likely to be fruitful in the proper diagnosis and treatment.

Illustrative examples of the "whole patient" approach to so common a problem as a little fluid in the ear are presented.

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# *Fragmentation of Health Services*

*(Reprinted from the Massachusetts Physician.)*

If one were to invent a phrase to describe the development of health services in the United States one might use "a many splendored but many splintered affair." At the national level, health functions are spread widely among a variety of departments, although the more significant ones are under the jurisdiction of the U. S. Department of Health, Education and Welfare.

A similar pattern exists in most states. There we find departments of public health, mental health, welfare with many health elements tied in, departments of education, agriculture, and other departments with responsibility for certain health functions. In a few states, as in most Canadian provinces, the departments of health are tied in with those of welfare as departments of health and welfare. This seems to be logical for a number of reasons.

At least one state—Michigan—has been concerned with this fragmentation of health responsibility. Governor George Romney made this statement regarding the situation:

> The reorganization of state services under our new constitution should be of interest and concern to every citizen and group. Here is an opportunity to streamline our state government so that it will provide improved service for all. The following are among the guidelines I think we should keep in mind as we consider this important opportunity:
>
> 1. Consolidate like functions insofar as practical for effective, economical services.
>
> 2. Design departments along lines which will promote maximum accountability and responsiveness to public needs and demands.
>
> 3. Provide for access and advice by groups and citizens interested in various functions.
>
> 4. Organize to strengthen the delivery of quality services to people by all needed units of government.
>
> 5. Develop agencies which will provide for maximum local opportunity for decision-making with minimum state control.

The Michigan State Health Commissioner, following up on his Governor's exhortation, stated:

> This is your opportunity to speak up about how your tax money is to be spent in the years ahead for state health services which will affect your life and that of your family and community. . . . Under this mandate (as implied by the new state constitution) we propose that a new pattern of health organization be developed for a new era of health in Michigan. . . . We propose an organization, unique in the states, which will concentrate our energies and competencies on getting quality health services to the community with great economy and impact. . . .

Fragmentation also exists at the local level. In an almost desperate attempt to develop community services under non-official auspices, many a community tolerates the development of this or that splinter of service in order to meet some problem, thereby creating yet another agency, rather than do the logical thing and ask some existing agency—official or voluntary—to take on the responsibility.

What Michigan is doing at the state level, all of the states—including Massachusetts—might well emulate. The local municipalities, too, should examine the question and bring more logic into their own community organization for the provision of united health services—especially those designed to meet the needs of the less privileged.

# *Centennial List of Speakers Grows*

**CENTENNIAL SESSION**
**Michigan State Medical Society**
**Detroit Cobo Hall & Sheraton Cadillac**

**Sept. 19**—Medicine and Religion Day
**Sept. 20**—Medicine and Business, Industry and Communications Day
**Sept. 21**—Medicine and Medical Organization Day
**Sept. 22**—Medicine and Science Day
**Sept. 23**—Medicine and Voluntary Health Day
**Sept. 24**—Medicine and Government Day

**PLAN TO ATTEND**

Committee work and staff planning for the MSMS Centennial has picked up speed. The program will be completed soon for the annual House of Delegates meeting, the expanded scientific sessions, and the special Centennial events.

"The big emphasis now is to urge each MSMS member to plan his September schedule so he can participate in at least one day of the Centennial, September 19-24," stresses Oliver B. McGillicuddy, M.D., MSMS President.

* * *

MAILINGS WITH the details, reservation forms, etc., will be made throughout the summer to the members. Special appeals also will be directed to the wives and the medical assistants, inviting them, too.

The Scientific Program Committee, with H. A. Towsley, M.D., Ann Arbor, as chairman, reports exceptional good luck in obtaining their first-priority speakers.

It is reported that both Michigan authorities and out-of-state dignitaries are especially attracted by the gala Centennial plans. For the first time, the scientific program will begin at Tuesday noon, and continue as in the past on Wednesday, Thursday and Friday. And for the first time, the programs, closed circuit television, demonstrations, and exhibits will be at the modern Cobo Hall.

* * *

FOLLOWING IS A list of out-of-state M.D.-educators who have already accepted invitations to speak at the MSMS Centennial Session:

T. D. Danowski, M.D., University of Pittsburgh
Sidney G. Margolin, M.D., Denver
Sidney Olansky, M.D., Emory University
William T. Foley, M.D., New York
Henry I. Ruseek, M.D., New York City
Adolph Rostenberg, Jr., M.D., Chicago
Malcolm A. McCannel, M.D., Minneapolis
Willard E. Goodwin, M.D., Los Angeles
Victor A. Politano, M.D., Miami
Jerome Hilger, M.D., St. Paul
Robert M. Smith, M.D., Boston
D. G. Decker, M.D., Rochester, Minnesota
J. Edward Berk, M.D., Los Angeles
James Sterner, M.D., Rochester, New York
Edward A. Gall, M.D., Cincinnati University
Carl A. Moyer, M.D., St. Louis, Missouri
H. G. Jacobson, M.D., Albert Einstein College
Harry A. Waisman, M.D., Madison
L. K. Pickett, M.D., New Haven, Connecticut
Horace L. Hodes, M.D., New York City
Herbert E. Kaufman, M.D., Gainesville, Florida
Matthew D. Davis, M.D., Madison
Paul Kabler, M.D., Cincinnati
Edwin A. Lennette, M.D., Berkeley

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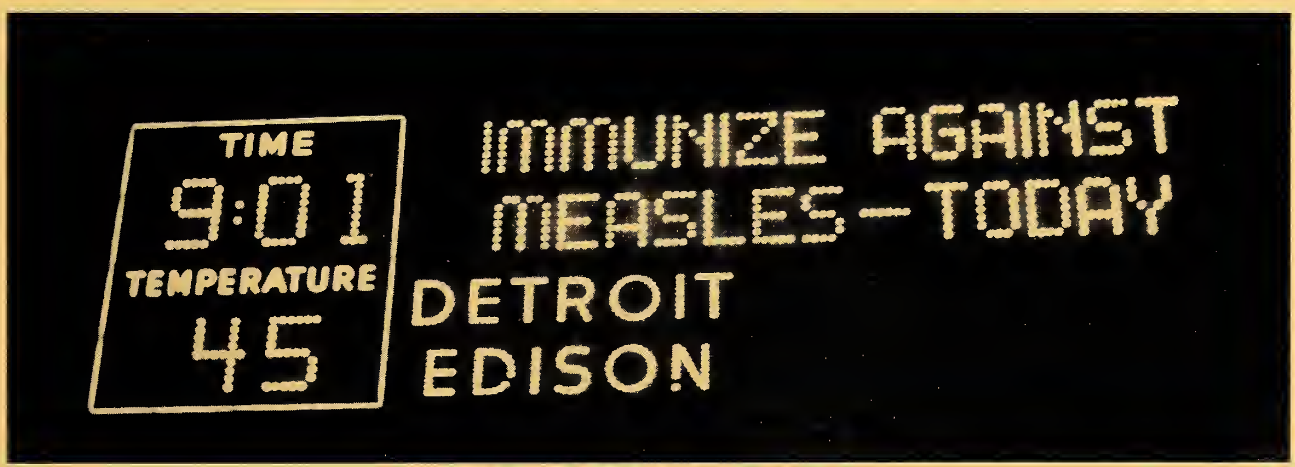
Thousands of motorists—thanks to Detroit Edison Company—learned about the MSMS Measles Immunization effort this spring as they drove down the Edsel Ford Expressway. The hugh Detroit Edison electric sign effectively helped to stress the "today" element.



# Dingman Gives Foster Lecture For Assistants

One-hundred and seventy-five medical assistants convened at the Michigan Union in Ann Arbor, April 25, to attend the Eighth Annual Educational Seminar of the Michigan State Medical Assistants Society. The highlight was the "L. Fernald Foster Lecture" delivered by Reed O. Dingman, M.D., of Ann Arbor. Doctor Dingman illustrated his speech on "Modern Concepts of Plastic Surgery" with numerous before and after slides.

The morning sessions covered the topics of "Operation Teamwork" by Kenneth K. Shook, D.D.S., Kalamazoo, and "The Eye in Systemic Disease" by F. Bruce Fralick, M.D., Ann Arbor.

Chairman Fae Wallace, assisted by the Washtenaw County Medical Assistants Society, hosted the meeting.

Guests at this seminar included Dr. and Mrs. Oliver B. McGillicuddy; Mr. Hugh Brenneman and Mrs. Marjorie Karker of the Michigan State Medical Society Staff; T. J. Trapasso, M.D., Sault Ste. Marie, and Otto K. Engelke, M.D., MSMAS Advisors; and Miss Helen Schick, Educational Co-ordinator, Michigan Blue Shield.

Certificates were presented to two Jackson County members—Mary Hutchins and Gertrude Russell—for completing the six courses in the In-Service Training Educational Program. Doctor Trapasso made the presentations on behalf of MSMAS.

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DETROIT—Tapes of the proceedings of the Third Wayne State University Workshop on the Late Sequelae of Massive Psychic Traumatization are available. Copies of the tape, from the 1965 Workshop, are available for a nominal charge from Henry Krystal, M.D., Department of Psychiatry, Herman Kiefer Hospital, 1151 Taylor Street, Detroit.

Congressman Durward G. Hall, M.D., left, receives the congratulations of F. P. Rhoades, M.D., new president, at the annual meeting of the Wayne County Medical Society. Doctor Hall was the featured speaker.

# *WCMS Installs Rhoades; Hears Hall; Elects Brush*

"Physicians will be reduced to government assembly-line clerks," commented Congressman Durward G. Hall, M.D., as he discussed Medicare at the recent annual meeting of the Wayne County Medical Society.

Congressman Hall (R-Missouri) indicated that when government becomes the third party, "our diagnosis and treatment will be examined as never before."

Congressman Hall also expressed the views that federal health programs would eliminate financial incentives for physicians and would reduce competition between doctors of medicine.

At the annual meeting, F. P. Rhoades, M.D., was installed as the new president to succeed W. C. C. Cole, Sr., M.D.

The recent WCMS balloting resulted in the election of Brock E. Brush, M.D., as the new president-elect.

Also elected were James C. Danforth, Jr., M.D., as the secretary, and Doctor Cole as a trustee.

Section officers, geographical representatives, delegates and alternate delegates to MSMS also were chosen.

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CLEVELAND—The American College of Obstetricians and Gynecologists has invited Michigan members to a District V meeting here October 28-31. The district covers Michigan, Ohio, Indiana, Kentucky and Ontario.

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## Blue Cross Grows

American Blue Cross membership has soared past the 60 million mark.

Antone G. Singsen, BCA vice president and treasurer, points out, "The growth of the Blue Cross system demonstrates its capacity to respond to the trust which millions put in this non-profit way of providing for their hospital care.

"The strength of the 77 Blue Cross Plans has been its flexibility and adaptiveness to local needs through each of the Plans which is free to serve its own community in an appropriate way," Singsen said.

# Push Legislative Efforts in State; "Watch Bulletins"

"MSMS members should continue to watch for latest federal and state legislative news in the Medigram and Special Legislative Bulletins," points out MSMS President Oliver B. McGillicuddy, M.D.

The issue of Medigram which went into the mail on Tuesday, May 18, brought the members up-to-date on the fate of the various Michigan bills. Commenting on the actions by the Michigan legislature up to the first "deadline" for reporting out bills, the May Medigram declared that "The legislature has, with only one major exception, taken those actions in nearly 20 individual cases which were recommended by MSMS."

Continued support and work by MSMS members is needed as the legislature nears its second deadline of June 22. On that day, the bills passed by one house must have been reported from committees in the other house.

The MSMS Legal Affairs Committee, staff members, and others are making a strong educational effort to stop SB 398 which would permit chiropractors to practice medicine. A detailed analysis of the bill was given May 14 to each state senator asking him to refuse to support this objectionable bill.

Vigorous efforts also are being made to oppose SB 63 declaring that podiatrists are "physicians and surgeons," and to prevent bills which would revise the Business Activities Tax so as to levy a 5 per cent tax upon net income instead of the present formula based upon gross receipts, and to levy a 4 per cent use tax upon all professional services.

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CHICAGO—Charles Demirjian, Wayne State University senior, received an honorable mention award and $50 in the SAMA-Mead Johnson Scientific Forum. His entry was "A Microelectrode Study of the Afferent Projections to the V.P.L. Nucleus of the Thalamus."

## NEWS BRIEFS:

# *He Who Runs May Read That...*

SAN FRANCISCO—The importance of self discipline as one grows older was stressed at the Assembly of American Academy of General Practice by Frederick C. Swartz, M.D., Lansing.

Careful weight reduction, good posture and daily mental exercise will help reduce physician infirmities in the later years, Doctor Swartz advised.

* * *

MIDLAND—A substantial minority interest in Bio-Science Laboratories, Los Angeles, has been purchased by the Dow Chemical Company. Bio-Science is an analytical testing laboratory, principally in the clinical diagnostic field.

* * *

SAGINAW—Looking far ahead on the calendar, the Saginaw Academy of General Practice announces that its "Vascular Clinic Day" will be held December 2 at the Bancroft Hotel.

A group of physicians and surgeons from the University of Denver Medical School will discuss "Renal and Hepatic Transplants and Related Problems."

W. C. Averill, M.D., will be chairman for the special day.

* * *

GAYLORD — Speakers are announced for the annual Claude Keyport Trauma Day, sponsored by the Northern Michigan Committee on Trauma of the American Surgeons at Hidden Valley Lodge, Gaylord, July 1.

Afternoon speakers will be John Bell, M.D., Chicago, on "Common Injuries to the Head"; Raymond C. Read, M.D., Wayne State University, on "Combined Bone and Vascular Trauma"; Richard C. Schneider, M.D., University of Michigan, on "Head Trauma in Football"; and a panel of Doctor Read, Doctor Schneider, and George Stilwell, M.D., Lansing, on "Multiple Injury" with the cases narrated by Ben Henig, M.D., Grayling, and moderated by Robert Berry, M.D., Flint.

The evening speaker will be E. J. Hill of Consumers Power Company.

Harry S. Kaplan, M.D., (right), professor of radiology at Stanford University, spoke at the University of Michigan, April 30, for the second annual Donald E. Johnson Lecture on Cancer Research. Chatting before the talk are, left to right: Fred J. Hodges, M.D., chairman of the U-M radiology department; Mr. Johnson of Flint; and William N. Hubbard Jr., M.D., U-M Medical School dean. (From the University of Michigan News Service.)

## MAP Board Elects Langius President

State Architect Adrian N. (Gus) Langius, Lansing, is the new president of the Michigan Association of the Professions. He succeeds Henry L. Homan, Grand Rapids dentist.

Serving with Mr. Langius will be Professor Edwin H. Young, U-M College of Engineering, as vice-president, and George B. Savage, Grand Rapids architect, as secretary. G. B. Saltonstall, M.D., Charlevoix, was re-elected treasurer.

Elected to the Executive Committee were W. Kenneth McKersie, D.V.M., Dearborn Heights; Douglas M. Ammons, R.Ph., Lansing; Rolland S. Strolle, Ph.D., representing the teaching profession, Kalamazoo; and George H. Cary, LL.B., Detroit.

JACKSON—"Physicians and ministers must learn to communicate," stressed Dr. Rev. Paul B. McCleave, AMA Director of Medicine and Religion, in his recent speech to the Jackson County Medical Society. The medical society should inform clergymen of some of the basic facts about illnesses so that they can administer help, he said. And, on the other side, Doctor McCleave added, a physician ought to understand why a Jehovah Witness believer can't accept a blood transfusion or what happens to a patient when he receives the last rites from his Roman Catholic priest.

### *Friends*

Advertisers in MICHIGAN MEDICINE are friends of the profession. By accepting their advertising we show confidence in them and in their services and products. They underwrite a large portion of the printing cost of MICHIGAN MEDICINE and thus help make it a quality publication. In return we place their messages on the desks of Michigan's physicians. Please familiarize yourself with their services and products, and let them know that you see their advertising in MICHIGAN MEDICINE.

W. D. Snively, M.D.

## Ask Residents, Interns, Seniors To Centennial

Special invitations will be extended to Michigan residents, interns and senior medical students to attend the Tuesday program of the Centennial Session, September 21.

The guests will be invited to attend the regular scientific programs at Cobo Hall in the afternoon after which a special affair is planned. W. D. Snively, Jr., M.D., Executive Vice President of Mead Johnson Company, will address the guests on "The Computer Approach to Diagnosis." A former physician in Illinois and a former Marine flight surgeon, Doctor Snively is listed in Who's Who in America and won the Billings Gold Medal of the AMA for an outstanding scientific exhibit.

A reception will follow the address by Doctor Snively.

NEW YORK CITY—The American Medical Association's 114th annual convention, June 20-24, in New York City is expected to be the largest in AMA history.

An attendance of 69,500, including 25,000 physicians, is expected. The largest previous AMA convention was in 1961 in New York City when 46,679 attended.

## WSU Alumni Install Jocz; Present Awards

The WSU School of Medicine Alumni Association at its annual banquet May 19 presented several awards and installed Marion W. Jocz, Grosse Pointe, as the new president. Also taking office were John M. Pendy, M.D., Grosse Pointe, as president-elect; Thomas M. Sullivan, M.D., St. Clair Shores, as secretary, and Warren O. Nickel, M.D., Dearborn, as treasurer.

Major awards went to Don W. McLean, M.D., Lathrup Village, MSMS Councilor and chairman of the board of the Wayne State Fund, and to Gordon H. Scott, Ph.D., Pleasant Ridge, now WSU vice president and formerly dean of the Medical School from 1950-61. Doctor McLean received a "Distinguished Service Citation," and Doctor Scott, a "Citation of Honor."

Six outstanding medical students received scholarship awards.

The WSU festivities were expanded this year into two days, with the dedication May 18 for the Medical Research Building, the first new structure on the developing medical campus. Tours, a symposium, etc., added to the special activities.

(Note: A photo of the new building appeared in the April issue and Alumni photographs will appear in the July issue.)

### *Judge*

The judge for the 1965 fall Art Exhibit for Michigan doctors and their wives to be held in Detroit at Cobo Hall during the annual session is announced by the chairman. Mrs. George E. McKeever.

The judge for the show is Robert J. Wilbert, associate professor of art at Wayne State University. Mr. Wilbert, trained at the University of Illinois, has exhibited locally and at the Metropolitan Museum of Art in New York, Chicago Art Institute, Pennsylvania Academy of Fine Arts and others.

# MSMS Centennial Series: 1961, 1962

## *Presidents Program, McNerney Report in Headlines*

One of the chief events of 1961 was the dedication of the new headquarters building June 4 at East Lansing. Approximately 1,000 doctors and friends participated in the program and open house.

The newest development in the Beaumont lore was the presentation of a bas-relief plaque of William Beaumont, M.D., to the Beaumont Hospital by the Oakland County Medical Society. And thanks to the contributions of friends in Oakland County, a copy has been made for the Beaumont Memorial on Mackinac Island.

* * *

A HIGHLIGHT of the 1961 annual Michigan Health Council State Conference was the establishment of a "Michigan Hall of Fame in Health." Sidney E. Chapin, M.D., MHC President, announced the recipients of the first five "Hall of Fame in Health Awards." They were the late L. Fernald Foster, M.D., W. K. Kellogg, the late Frederick A. Coller, M.D., Thomas Francis, Jr., M.D., and William J. Norton. Doctor Foster was one of the founders of the Michigan Health Council and served as secretary of the MSMS for many years. Mr. Kellogg founded the W. K. Kellogg Foundation. Doctor Coller was recognized for his outstanding contributions in the specialty of surgery and Doctor Francis for his leadership in the field of epidemiology. Mr. Norton is nationally known for his services as president of the Children's Fund and his work in the development of the United Community Services in Detroit.

On April 16, 1961, a special session of the House of Delegates was held in the Kellogg Center, East Lansing. The meeting was called to discuss implications of the federal bill which would provide health services to the aged through the Social Security system, and to develop and implement a necessary informational campaign to the public through MSMS members.

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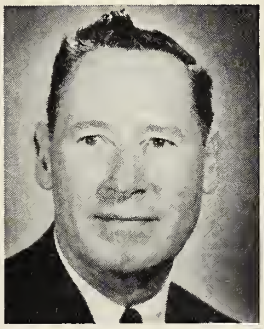
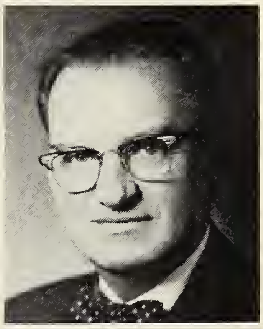
*Leading up to the MSMS Centennial in 1965,* The Journal *is printing a series of articles by William J. Stapleton, Jr., M.D., Detroit, who is the MSMS Historian. This series began in the September, 1963, number of* The Journal *and will continue through August, 1965.*

The Author
WILLIAM J. STAPLETON, JR.
M.D.
MSMS Historian



Kenneth H. Johnson, M.D.
MSMS President
1960-61



Otto K. Engelke, M.D.
MSMS President
1961-62

The American Society of Association Executives presented an award to William J. Burns, who was executive director of the MSMS. The plaque for the best executive of a statewide organization was awarded to Mr. Burns by a judging committee of university leaders.

* * *

"DECISION: The Moment of Truth" was the name of a new TV series sponsored by the Michigan Association of the Professions. It is telecast on Sunday mornings, to depict the activities of the member-professions of MAP.

The Presidents Program, approved by the 1960 House of Delegates, began to make scientific impacts on the medical profession, on other scientific societies affiliated with or ancillary to the Michigan State Medical Society, which were for the benefit of better health of the people. The impact of this five-year program is one that was felt gradually, with the effort culminating in 1965 coincident with the One Hundredth Anniversary of the founding of the Michigan State Medical Society.

No Michigan Clinical Institute was better received by the medical profession of Michigan and neighboring states than the 1961 refresher course held in Detroit in March. Attendance was 2,626 including 1,450 M.D.s (190 more M.D.s than at the 1960 MCI). Attendance at the closed circuit color television programs was eminently satisfactory to the MCI Committee and to Smith Kline & French Laboratories, the sponsors; also attendance at the 8:00 a.m. discussion groups was far greater than anticipated.

The University of Michigan's Study of Hospital and Medical Economics, including Blue Cross and Blue Shield (the McNerney Report), financially sponsored by the Kellogg Foundation at a cost of $380,000, was completed after more than three years' work. This subject was considered at every meeting of The Council during the year.

* * *

The 1961 House of Delegates authorized a new Medical Socio-Economic Committee and Department. The new department was established with a trained socio-economist as research director, and with a prominent university socio-economist retained as a consultant.

The 1960 House had recommended the appointment of a Medical Care Study Committee to investigate this entire area of concern and the study committee presented a report to the 1961 House to consider. The 1961 House of Delegates took action in six areas: (1) that MSMS immediately establish a Medical Socio-Education Committee; (2) that all component medical societies and specialty organizations create similar committees; (3) that the MSMS Medical Society Economics Committee shall consist of a chairman and six members to serve for a term of three years ;(4) that MSMS should secure an economist; (5) that an approximate budget of $30,000 be approved for the first year of operation; and (6) that a $5.00 increase in MSMS dues be approved to finance the project.

* * *

DURING THE YEAR The Council met eight times, and 912 items were considered. There is not room to give details as to the work of this important group. I salute the members for the time, energy and expense it cost them to leave their practice and work for the members of MSMS.

The MSMS members expressed their views on Social Security. Returns from the total membership of 6,775—5,520 members, 817 were usable. Tabulation of the results of the membership as a whole indicated a very high portion of the membership (better than eight out of ten) in favor of voluntary participation in Social Security and a big percentage (seven out of ten) voted against making it compulsory.

In March, the doctors were urged to use their influence against HR 4224 regarding compulsory health insurance.

* * *

THE BIDDLE LECTURE was given by John S. DeTar, M.D., Milan, whose topic was "The Doctor's Dilemma."

The Michigan Association of the Professions continues to provide opportunities for important relationships between the professions. The annual MAP Congress honored William M. LeFevre, M.D., Muskegon, the first MAP president.

For the first time, a short printed "Annual Report of the Michigan State Medical Society" was mailed to each MSMS member. (The Report accompanied the brief "Unofficial Proceedings of the 1961 House of Delegates.") Reports from members indicated that this new service was well received and highly appreciated.

The Council and the Ingham County Medical Society provided a "Medical Aid Station" for the Constitutional Convention in Lansing. The Con Con delegates adopted a resolution voicing appreciation.

* * *

AFTER LONG AND detailed study by members of The Council and the Medical Socio-Economics Committee, an official MSMS statement was presented February 3, 1962, to the Governor's Commission on Prepaid Hospital and Medical Care Plans. In the statement, MSMS stressed its position that "The United States has the best quality of medical care in the world; and, in our opinion, the best system for distributing that care." Answers were provided to various questions raised by the commission. Our statements included the following: (1) MSMS has taken the leadership to insure the highest possible medical care for the general public and that the doctor is the key person in the effective quality control methods in the hospitals; (2) proper utilization of medical facilities is a vital concern of the doctor, component societies and MSMS; (3) that the government agencies should reimburse all hospitals for the actual per diem costs as determined by quarterly Blue Cross audits; (4) MSMS, since the inception of Blue Shield, has supported the community rating principle for the benefits of the entire community; (5) that MSMS and the Michigan Health Council shall continue to work diligently for greater health manpower in Michigan; (6) MSMS believes that the Blue Shield Board should continue to have public representation—and that the board could not be improved by a change in composition; (7) MSMS has encouraged M.D. participation in Blue Shield but does not believe that coercian should be used to obtain participation; (8) MSMS does not agree with the suggestion that a permanent commission be established to watch progress on the Study recommendations.

## Coming in July

*Watch for an important article on the Unreliable Professional Blood Donor in the July issue. In addition, an effective technique for treatment of unilateral pain in the head will be described under the title "Syndrome of the Greater Occipital Nerve."*

*George L. Waldbott, M.D., Detroit, will briefly review the effective treatment of asthma, and José Llinas, M.D., Jackson, will bring us up-to-date on Community Mental Health in Michigan. An interesting report of contact dermatitis due to topical steroids, with two interesting cases, is presented from Wayne State University.*

*July will also feature a special communication from John M. Dorsey, M.D., in which he presents his personal philosophy under the subject "Hypnosis—Every Individual's Educational Problem."*

# EXPLAINS USE OF LABORATORY DATA IN RABIES TREATMENT

### By Michigan Department of Health

The decision whether or not to institute specific rabies prophylaxis is often a difficult problem for the practicing physician.

The recommendations of the WHO Expert Committee are very helpful in setting a standard guideline. It must be realized, however, that these recommendations are only a guide, and the responsibility for the actual decision of treatment or no treatment falls upon the physician.

Following an animal bite there are three parts to the decision as to the mode of treatment of the bite: clinical, epidemiological, and laboratory.

Clinically, animal bites must be assessed as to severity and site, not only for purposes of determining whether or not to initiate rabies vaccine, but also to assess the likelihood of infection or other complications. Any animal bite should have a thorough scrubbing and cleansing with either 20 per cent soap solution or Zephiran, 1-2 per cent aqueous solution, as soon as possible. In laboratory experiments with guinea pigs, this treatment alone decreases the likelihood of rabies transmission markedly.

In addition, such treatment will help prevent tetanus or other infections of the wound, although it will not replace the appropriate use of antibiotics or tetanus toxoid or antitoxin. This prompt initial wound treatment is always the first line of defense.

When deciding whether or not specific treatment in the form of rabies antiserum or rabies vaccine should be initiated, epidemiological information must be added to clinical judgment. This means that in addition to considerations of the severity and location of the wound, considerations of the likelihood of the biting animal being rabid must be added.

For example, if the animal is unlikely to be rabid, such as a mouse or rat, the decision will usually be not to treat. On the other hand, if an animal is likely to be rabid, such as a bat or skunk, the decision will usually be to treat unless unusual circumstances prevail. There are many situations in-between where the physician must decide, using his best judgment and the help of his health officer or epidemiologist. The decision to initiate antiserum or vaccine treatment should usually be made promptly before a definite confirmation of the status of the animal is available.

If the biting animal is not available, the final decision must rest on clinical and epidemiologic grounds. If the animal is available, and is alive and well, it can be observed after the initiation of treatment. If the animal remains well for 10 days, one may assume it did not have rabies—with the possible exception of the bat. If the animal was sick, dead or killed, examinations at the laboratory are necessary to confirm whether or not the animal had rabies.

Laboratory examination constitutes the final assessment of whether or not the animal was rabid.* The initial laboratory report on an animal is sent out within one day of receipt at the Division of Laboratories, Michigan Department of Health.

This report is based on the identification of inclusion bodies or aggregates of viral material in the brain cells of the animal by fluorescent antibody staining if the specimen is received between Monday morning and Friday noon. If the specimen is received between Friday noon and Monday morning, the initial report will be based on the finding of Negri inclusion bodies by direct staining. This test is not as sensitive as the FA examination, but if positive, it is sufficient evidence for starting treatment. All specimens examined by direct stain will have FA examination completed on Monday.

The fluorescent antibody (FA) technique is a relatively recent addition to the examination methods. It is a very reliable test, and only rarely has an animal that was negative on FA examination been positive on mouse inoculation (1 in 300 tests in our experience). The FA test is reliable enough that this early report can usually be used to make a definitive decision on treatment.

For example, suppose a child is bitten on the leg by a wild animal that dies or is killed. A positive FA test will indicate that vaccine should be continued or initiated if it has not already been started. A negative FA test will confirm the initial decision not to vaccinate or will usually be a basis for stopping a vaccine. However, because rare false negatives do occur, the physician may decide to continue vaccine in a patient having a severe bite from an animal that has a high suspicion of being rabid. Because of these rare false negatives, mouse inoculation is done for all specimens except rodents.

The final report is positive if either the FA slide or the mouse inoculation is positive, or if both are positive. It should also be noted that since rodents are almost never rabid, only the fluorescent antibody test is carried out on those specimens.

It is hoped that this note will clarify the significance and value of the laboratory tests for rabies that are done by your Michigan Department of Health Laboratories.

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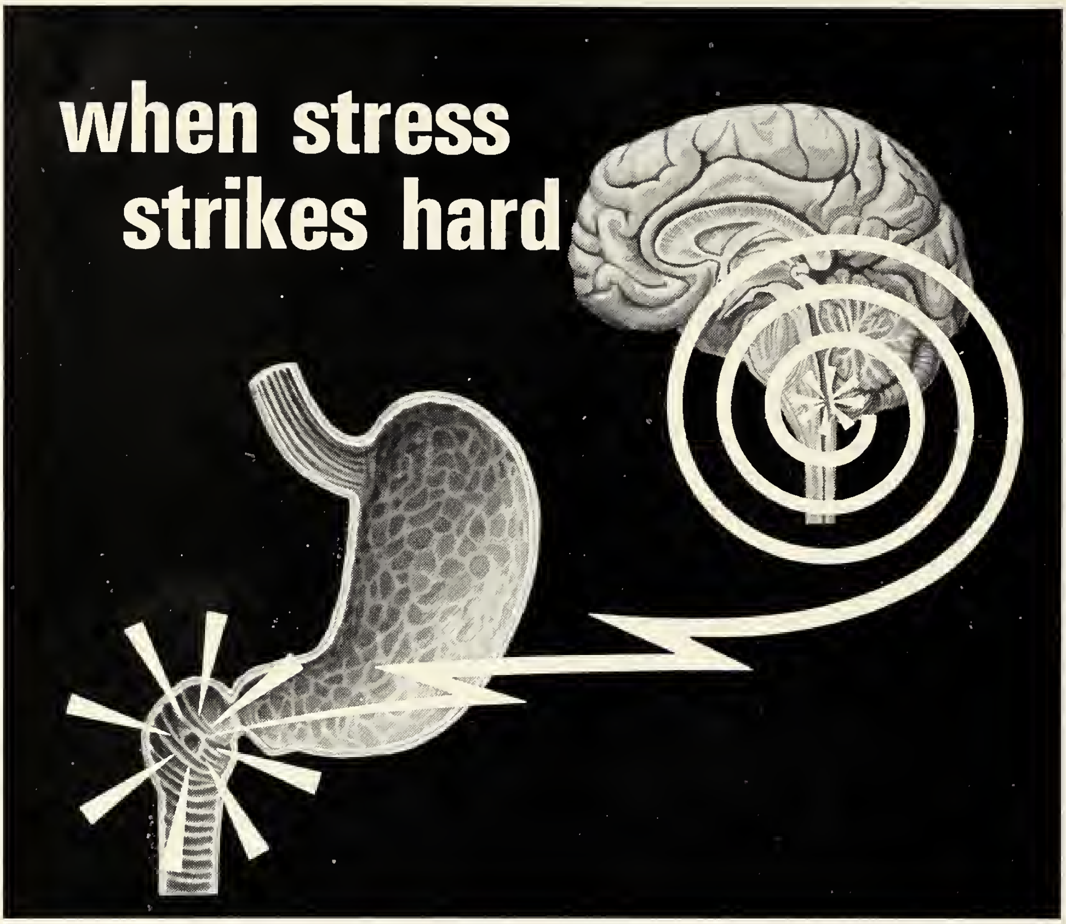
*Bats are an exception because they may carry the virus without having brain involvement.

## Tells Drug Facts

A wide array of facts and figures on the prescription drug industry is contained in a new edition of "Key Facts" published by the Pharmaceutical Manufacturers Association.

Copies are available on request from: Public Information Office, PMA, 1155-15th Street NW, Washington, D. C. 20005.



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## EDITORIAL VIEWS

# INTERN – WHERE ARE YOU?

On the first of July, 1965, the hospitals in the state of Michigan will awaken to the fact that they have fewer interns than at any time in the past five years.

The down trend has been steady and progressive with 348 interns in the state from all sources in 1961, 342 in the years 1962 and 1963, 323 in 1964 and on July 1st there will be 275. This statewide loss of 48 filled internship positions represents a significant drop and suggests an acceleration in the downward turn unless a means can be found to reverse the direction of the trend.

Thirty-eight hospitals in Michigan participate in the National Intern Matching Program. Six hospitals in the state filled their intern quota and six will have no interns. Still another six hospitals will have either one or two interns unless they should decide to release the single matched applicant from his commitment.

* * *

NINE HOSPITALS in the state filled 50 per cent of their internships and 17 filled fewer than 50 per cent but had at least one. Evaluation of the data would suggest an all or none phenomenon wherein a hospital fills 50 per cent or more of its places or does not do well at all.

St. Joseph Mercy Hospital in Ann Arbor, Children's Hospital, the Henry Ford Hospital, and the Sinai Hospital of Detroit, filled their quotas, as did the Blodgett Hospital of Grand Rapids and the Bronson Hospital in Kalamazoo. The University Hospital in Ann Arbor filled most of its places but not all, and the situation was similar at the Oakwood Hospital in Dearborn, Borgess Hospital in Kalamazoo and the Saginaw General Hospital.

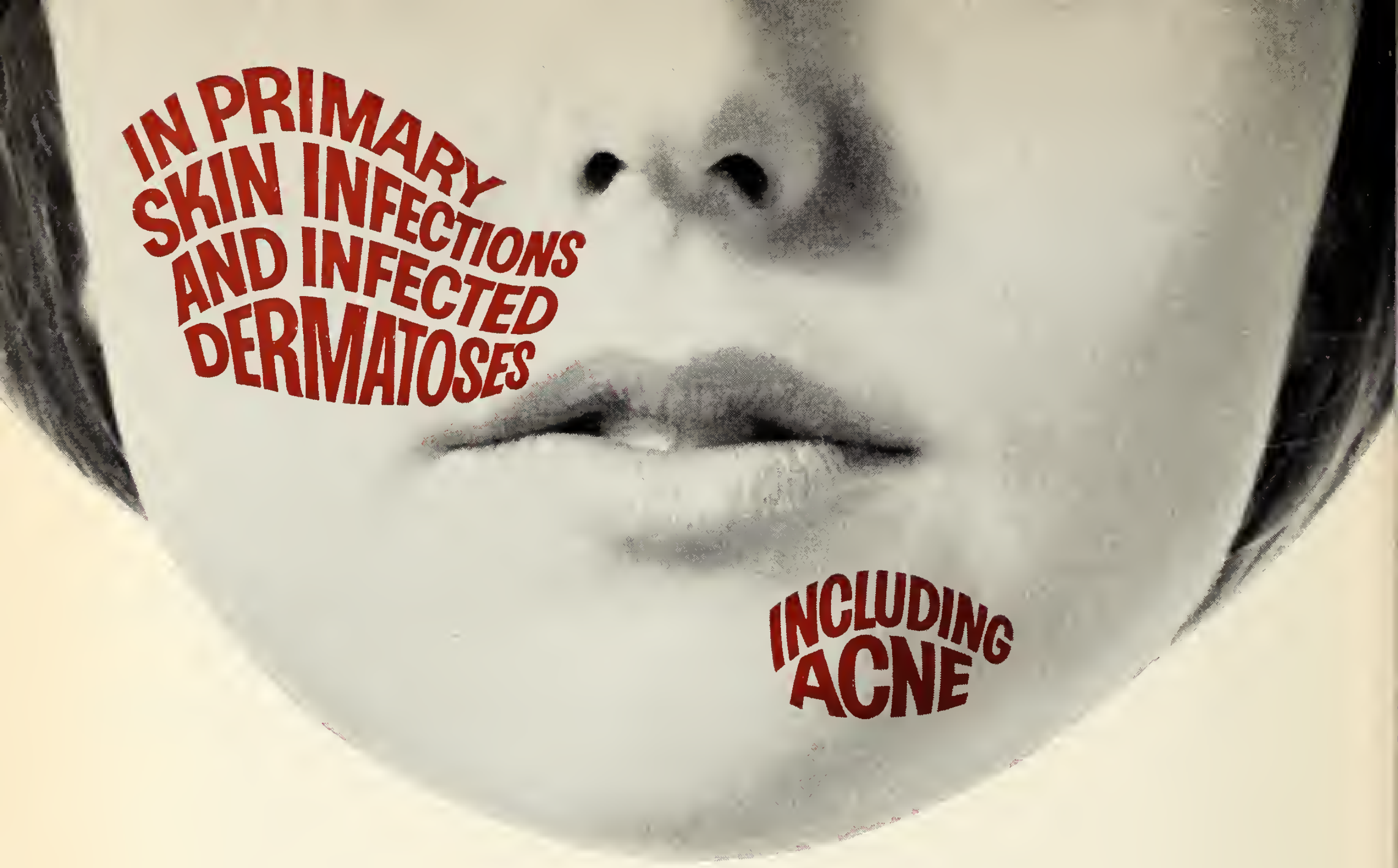
At the University of Michigan, only eight of the 1965 graduating seniors will intern at the University Hospital out of 82 interning in hospitals located within the state of Michigan. An equal number will intern in hospitals outside of the state. Ten Michigan graduates will intern in military or public health service hospitals.

Those graduates leaving the state include 22 in California, nine in Illinois, seven in Ohio and Pennsylvania, five each in Colorado, Maryland, and New York, with the remainder scattered across the nation in the states of Connecticut, Hawaii, Indiana, Massachusetts, Minnesota, Missouri, New Mexico, Rhode Island, Texas, Washington, and Wisconsin. More students have selected straight or mixed internships, although this choice is still made by only a quarter of the class.

* * *

THE MEDICAL graduate of today is a reasonably sophisticated individual. It is not unusual for him to desire a change of scenery during his internship year and to plan on returning to Michigan for further training but his mind may change again while he is an intern.

The trend toward the high-salaried internship has slowed and concern for quality of the educational experience and the interest and enthusiasm of the staff continues to grow. This is not to say that the applicant does not consider the economics of the situation, but rather that he seeks a good educational experience that has adequate economic support. Most students with whom your editor has visited appear to consider a salary of $300 a month as a reasonable sum and from that baseline look at other characteristics in the hospital. Eighty per cent of the graduates look forward to one or more years of training beyond the internship and the choice of a hospital as a place to intern seems to be influenced by the character and quality of additional training in that hospital and by the reputation of the hos-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pital as a springboard into a residency program at another institution, usually one with a medical school affiliation.

* * *

CONTINUING POSTGRADUATE medical education in formalized programs is an endeavor of ever increasing importance in the United States. The hospitals of Michigan have played, and should continue to play, an important role. An evaluation of the quality of our internship programs is indicated and should be undertaken by each hospital staff without delay.

# RESTORE ALL THINGS

**By John C. Duffy, M.D.**
**Rochester, Minnesota**
**Grand Prize Winner**
**In Samma Opinion Contest**

The spectacular progress in medicine has been tangible goals in disease prevention, restoring health, and prolonging life. But, have we expressed the length and breadth of the physician's role and responsibility in our society?

If education is to produce individuals who are capable of handling specialized occupations, the question has been answered. Surely, our professional education offered more than the training of a technician. We learned to think independently, to appreciate the good and beautiful, and discern what is true and right.

Therefore, we serve mankind as both scientist and humanist. The latter role, unfortunately, is all too often blurred in scientific preoccupation. Yet, the fundamental meaning of humanism is to study and reveal all the richness of Being and its Creator. Where is this conception more clearly seen than by the "healer" who approaches his patient and his fellow man as a creature created in the image and likeness of his God?

We live in an age of "fragmentation," but our ethics and professional ideals will not permit us to accept the view that the human race is embarked on a curious voyage among the stars, without purpose or meaning. We must work, work as physicians and humanists, for a society of men made whole—we must "Restore All Things."

# A STEP AHEAD

Michigan Medicine notes with pleasure the pending establishment of a Hemophilia Fund in Michigan. This development on the part of a voluntary health organization rates special commendation to the Michigan Chapter of the National Hemophilia Foundation.

An article about this new Michigan project may be found on page 439.

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## *Suggests Several Chiropractic Weaknesses*

*(Reprinted from "The New Physician," March, '65.)*

The Department of Investigation of the American Medical Association recently announced that five of seven schools of chiropractic in the United States contacted in a study of admission standards do not conform to their own professed standards for admission. "Despite the many declarations by chiropractors that their schools are professional in character, the study indicates that one does not have to be a high school graduate to be admitted to . . . chiropractic schools. Yet, upon graduation, these persons are issued diplomas which ostensibly confer upon them the right to be called 'doctors.' "

The report also said there was a basic weakness in the stated requirements because few individuals coming directly from high school are mature enough, especially intellectually, to undertake satisfactorily what should be the equivalent of a medical school course. In addition, it stated that since none of the sciences taught in high school are a prerequisite for admission, the teaching of such sciences as biology and chemistry must begin on the lowest level.

An editorial in *JAMA*, "Chiropractic as a Career," on November 23, 1964, warned, "Their need for students evidently causes most schools of chiropractic to accept persons who would be unacceptable to most undergraduate colleges." High school students and their guidance counselors should be advised of the "inadequacy of chiropractic education and to the fact that a career in chiropractic is a career in cultism," the editorial said.

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# OUR STATE SOCIETY

## Time to Think About Resolutions

"Now is the time to prepare resolutions for introduction at the Centennial Session of the MSMS House of Delegates, September 19-20-21 in Detroit."

So declares J. J. Lightbody, M.D., Detroit, Speaker of the MSMS House of Delegates.

"The delegates are urged to help their county medical societies develop possible resolutions now before the summer months disrupt the county business meetings," comments Doctor Lightbody.

"We'd like to have the resolutions at least 30 days before the opening session, or sooner if possible," he added.

## MSMS Boosts Use Of Measles Vaccine

Measles vaccinations in Michigan increased to five times the normal rate during the first two months of the recent intensive public service campaign conducted by the Michigan State Medical Society.

Oliver B. McGillicuddy, M.D., MSMS President, said, "We have made remarkable progress, thanks to the splendid support our campaign has received from county medical societies, health officials, and the news media."

During February and March, an estimated 100,000 Michigan children were vaccinated against measles as compared to 20,000 who would normally have been inoculated in that two-month period.

Although these reports are very encouraging, much remains to be done in the war against measles, Doctor McGillicuddy emphasized. "We must not lose sight of the fact that more than 600,000 Michigan children still remain unprotected against this crippling disease.

## Mediscene

**June 10-12**—Michigan Orthopaedic Society, summer meeting, Hidden Valley, Gaylord.

**June 11-12**—Upper Peninsula Medical Society, Marquette.

**June 20-24**—114th Annual Convention of American Medical Association, New York City.

**July 1**—Keyport Trauma Day, Gaylord.

**July 29-30**—Coller - Penberthy - Thirlby Medical Conference, Park Place Motor Inn, Traverse City.

**Sept. 16-19**—American Medical Writers Association, Statler Hilton, Detroit.

**Sept. 19-24—MSMS Centennial Session, Cobo Hall and Sheraton Cadillac Hotel, Detroit.**

**Sept. 21-24**—Woman's Auxiliary to Michigan State Medical Society, Ponchartrain Hotel, Detroit.

**Sept. 21-24**—5th Annual Michigan "Doctors and Wives" Art Exhibit, Cobo Hall, Detroit.

**Sept. 22-23**—Michigan Medical Assistants Society Annual Meeting, Statler-Hilton, Detroit.

**Sept. 23**—Michigan Health Council Annual Meeting, Cobo Hall, Detroit.

**Nov. 3**—Diabetes Day, Genesee County, Flint.

**Nov. 4**—Southwestern Michigan Clinic Day, Battle Creek Country Club.

**Nov. 7-13**—Community Health Week.

**Dec. 2**—Saginaw Academy of General Practice—Vascular Clinic Day, Bancroft Hotel, Saginaw.

## PG Clinic Named to Pay Honor to Dr. Mustard

The memory of Russell L. Mustard, M.D., who died April 1, will be perpetuated by annual clinic day activities at Battle Creek as a result of a resolution unanimously approved by the Calhoun County Medical Society. The all-day fall clinic will be named for Doctor Mustard.

He originated the program five years ago. An outstanding speaker each year will give a Dr. Russell L. Mustard Memorial Lecture. Memorial contributions to the lectureship fund are being accepted.

For many years, Doctor Mustard was one of the leaders in the MSMS Postgraduate Medical Education efforts.

### *Boosts Measles Vaccines*

"Measles can be licked. The vaccines are available. They work. They are safe. Now it's up to the medical profession and parents to see that children get the shot.

"Medical authorities say it's only a matter of time until measles is almost as rare as polio."

—Changing Times,
The Kiplinger Magazine
April, 1965

# *King-Anderson Bill Draws Fire*

Many words have been spoken and written about the Administration's King-Anderson Bill since it cleared the House of Representatives and waited for Senate action.

Following are some excerpts from various sources which will be of interest to MSMS members.

## Congressman Ford Calls It "Regressive Tax"

(Editor's Note: The following is excerpted from "Your Washington Review," newsletter of Congressman Gerald R. Ford, Michigan Republican, for April 14, 1965.)

"It is difficult to understand how those who allege they 'care for people,' can insist on higher and higher payroll taxes (under the King-Anderson package). And the tax is a regressive one, inflicting the greatest burden on those least able to pay.

"Under the schedule as adopted, the employee making $5,600 a year or more and now paying $172.80 in Social Security taxes next year will be charged $224. In 1969 this will go to $246.40. In 1971 the taxable base goes to $6,600 and anyone earning that much or more will pay $290.40 which will be raised to $316.80 in 1973. The rate scheduled for 1973 and after is 4.8 per cent on everything up to $6,600. The employer will pay a like amount, while self-employed persons will pay a tax of 7 per cent. Because both the rate and the base can be increased at any time, we know that the amounts mentioned are minimal. As billions of dollars are drained from the Social Security Trust Fund, either the tax rate or the tax base or both will be increased.

"A payroll tax of this nature is a regressive tax. Its greatest burden falls on those less able to pay. For instance, the $224 tax is 4 per cent of the wages of a worker earning $5,600. But a person making $30,000 pays exactly the same tax which is only 7/10 of one per cent of his income.

"With this sort of a regressive payroll tax there are no exemptions, no deductions, no exclusions, and no tax credits. No consideration is given to the taxpayer's ability to pay. No consideration is given to the size of his family, to the cost of maintaining the family, nor to any special financial circumstances involving the individual."

## Looks Like a Camel!

(Editor's Note: Following are excerpts from an article in Monthly Review, the publication of the Insurance Economics Society of America, Vol. 21, No. 10.)

"The camel is such an ugly beast (so the saying goes) that it looks as if it had been put together by a committee. The comment is apt in considering the 'medicare' bill that emerged from the House Ways and Means Committee. The ungainly product of the committee process is full of humps and has doubtful workability."

* * *

## Sees Lifetime Payments Amounting to $84,139

(Editor's Note: The following comments were made during the House of Representatives' hearing on the King-Anderson Bill by Rep. Harold Collier, Illinois Republican. They are excerpted from the Congressional Record for April 8.)

"For years Social Security has been a bargain at the price tag it carried for millions of retired citizens. But it certainly will not be a bargain for

LEGISLATIVE AFFAIRS

those who will be entering the labor market tomorrow or in the years ahead.

"In fact, I think that many workers today will be somewhat disenchanted as the whole story of the Social Security payroll tax is unfolded. If you look briefly at the Social Security system, you get some idea of what I mean in dollars and cents. I trust that as a supporter of the principles of Social Security, I will not be charged with tearing up a Social Security card in the next election.

"Perhaps the best way to emphasize this point is to take the example of a young man who is entering the labor market next January first at the age of 21 years. Let us assume that he were to deposit each year the contribution that he will be paying as a payroll tax in any financial institution with an interest rate of 4¼ per cent per annum.

"Do you realize that at the age of 65 he would have $42,000? Now add thereto another $42,000, which is the matching sum his employer or employers would pay into the trust fund over the duration of his pre-retirement years, and you come up with a figure of $84,139.

"If both he and his wife live to be 77 years of age and draw the maximum Social Security benefits for a married couple for each year from the date of his retirement, he stands to draw in total retirement benefits $6,000 less than his own interest-compounded contribution and more than $48,000 less than the interest-compounded, combined contribution of he and his employer.

"If you would like to figure out what the self-employed person under the same conditions would get, you will find a much greater disparity.

"You might respond by saying, 'Look at the protection he has under this program all these years,' but I submit that every protection provided under the Social Security program could be purchased privately and leave this young man with a very substantial balance at the age of 65, which he of course could leave in a savings account to draw interest while using only the funds he needed to live comfortably in his retirement years.

"I submit that these figures have been based upon no further changes in the Social Security law beyond those which are before us today; no further increase in benefits; no further liberalization and no further increase in payroll taxes. But then you and I know that it has become almost standard procedure to increase Social Security benefits from time to time out of need through increased cost of living, as well as a smattering of political expendiency or motivation."

* * *

## Will Indigent Ill Have No MD Care?

(Editor's Note: The following is excerpted from an editorial in the Detroit Free Press, March 25, 1965.)

"The outcome (of the Medicare Bill) doesn't make for consistency. The basic question of

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whether medicare should be voluntary or compulsory isn't answered. It's straddled. The government would dun you so that it could pay your hospital costs, but you would have to decide for yourself whether to take out doctor insurance.

"What is going to happen to the indigent ill without the foresight to take out medical insurance? They have a right to hospitalization, but no doctor."

* * *

## Points Out Program "Won't Be Free"

(Editor's Note: The following paragraphs are from a Chicago Tribune column, of April 12, 1965, by Columnist Walter Trohan.)

"The Medicare Bill does provide some checks on doctors' fees, which is the beginning of federal control. Although proponents of medicare deny that doctors are destined to become regimented servants of the state rather than free practitioners of the art of healing, the world trend is toward socialized medicine and America is not bucking the general trend toward socialism.

"The program is being sold as 'free' or largely so. It won't be free. It will have to be paid for, one way or another. It will be paid for by higher social security taxes to begin with, but will undoubtedly have to tap general taxes in time."

* * *

## Sees Need to Encourage Individual Responsibility

(Editor's Note: The Editor of Arizona Medicine, Robert F. Lorenzen, M.D., made the following statements in a longer editorial in his March issue.)

"The measure of a 'Great Society' lies not in how many Federal programs are enlisted in behalf of the inept, but rather in how many of its individual citizens are encouraged by government to assume responsibility by themselves, for themselves and their neighbors without waiting for authorization from Washington.

"When this encouragement is given both the individual and the nation will be cured of paralysis of the will."

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# COUNTY SOCIETIES

## COUNTIES ALERTED TO "PROJECT HEAD-START"

The MSMS Committee on Child Welfare recommends that each county medical society be alerted to the new federal project called "Project Head-Start," a nation-wide pre-school phase of the War on Poverty.

The MSMS Committee on Child Welfare "urges county societies to make a strong effort to be sure that all the children involved have an excellent health appraisal and good follow-up, and that this be done with the cooperation of the local sponsoring agency."

Directed by the Federal Office of Economic Opportunity, this new program will pay for 90 per cent of the cost where local communities organize and operate such a two-month program this summer for pre-school children. The local community must furnish the remainder in either cash or kind. The health aspects of the project involve health evaluation, and also remedial and developmental health programs.

The AMA has taken no action relative to Project Head-Start, but staff officials recommend that the health aspects "should be formulated under the guidance of the local medical society.

"It is important to make sure that those health procedures that may be involved are in accord with acceptable medical practices and policies," the AMA suggests.

Information may be obtained from Project Head-Start, Office of Economic Opportunity, Washington, D. C. 20506.

## 75 Years Observed By Clinton Society

At a recent special dinner meeting, the Clinton County Medical Society commemorated its 75th anniversary at St. Johns. F. S. Smith, M.D., President, St. Johns, declared that "the Clinton County Medical Society has continuously served the health and welfare of this county since its beginning on March 14, 1890, and it dedicates itself to ever greater service.

"The early meetings were held at 1 p.m. on the first Friday of each month and it seems likely the doctors used up the best part of a day to attend the meetings," Doctor Smith observed. No meetings were held in January or February, which were probably the coldest and poorest months to travel in a horse and buggy. At each of the early meetings, a different doctor in order was assigned to give a scientific paper.

The size of the Clinton County Medical Society has not changed much. There were 15 charter members, and there are now 17 members.

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## Ingham Aids Polio Fund

The Ingham County Chapter of the National Foundation has received a check for $4,103.91 from the Ingham County Medical Society. The check, representing the proceeds from the polio campaign, helped to mark the 10th anniversary of the approval of Salk vaccine—the first big step toward the prevention of polio.

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## Kent Hosts Clergy

More than 400 physicians and clergymen participated in the Kent County Medical Society program, "The Physician, The Clergy and The Whole Man," in cooperation with the Grand Rapids Ministerial Association.

The AMA film, "The One Who Heals," was shown and Ralph Blocksma, M.D., moderated a panel of Rev. Edward J. Bielskas, Rev. Frederick Olert, Charles E. Farber, M.D., and Edward Y. Postma, M.D.

E. H. Fuller, M.D., was program chairman.

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## Monroe Splits Proceeds

Checks of $6,700 were presented by the Monroe County Medical Society from the polio campaign proceeds to the Memorial Hospital and the Mercy Hospital, and also to the National Polio Foundation. The proceeds totaled more than $20,000. Shares of the proceeds were also given to the Monroe County Auxiliary Police, Radio Emergency Associated Citizens Team, and the Amateur Radio Emergency Corps.

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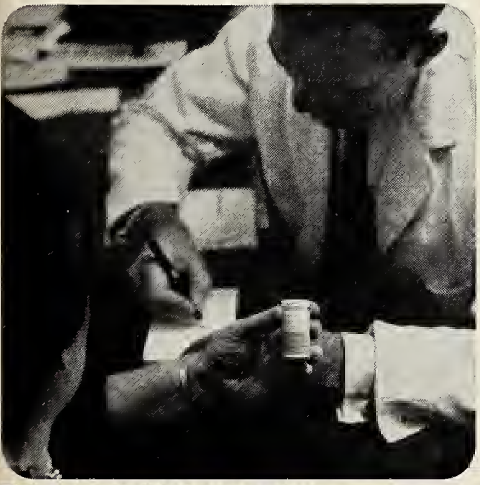

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## E. W. Morris Cited

An engraved plaque was presented to Emory W. Morris, left, president and general director of the W. K. Kellogg Foundation, by Richard J. Campbell, M.D., of Battle Creek, at a recent meeting of the Calhoun County Medical Society. The award was "in grateful acknowledgment of his many contributions to health and education in local, state, national and international communities; the deeds of this public-spirited citizen can serve as an inspiration to the youth of today." (Battle Creek Enquirer and News Photo)

## *Lenawee Physicians Aid Tornado Victims*

Within several days after the devastating tornados on Palm Sunday, the Lenawee County Medical Society gave $5,000 for disaster relief.

In making the presentation to the local Red Cross chapter, President Richard D. Coak, M.D., Tecumseh, said, "It is our hope that other organizations and individuals, too, will join in this effort to help our fellow man at this time of dire need."

## Helps Shiawassee Clinic

The Shiawassee County Medical Society contributed the proceeds of the oral polio drive to local needs. Proceeds of $13,000 were given to help equip a new County Mental Health Clinic, and $500 was given to the local chapter of the National Foundation.

## *GREENE COUNTY DOCTORS SING FOR SCHOLARSHIPS*

How can a county medical society of barely 150 members grant scholarship loans to three dozen young doctors-to-be?

The Greene County Medical Society, Springfield, Mo., is doing precisely that—through the talents of its "Singing Doctors." The group's three record albums of "Medical Hit Parade" satire have now grossed over $75,000, with all proceeds going to the Society's scholarship foundation.

The albums—available exclusively by mail from the Society's headquarters in the Professional Building, Springfield, at $3.25 each, postpaid—are the brain child of a 41-year-old surgeon, James T. Brown, M.D., who composed the 60 parodies and organized the singing group.

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# Coller-Penberthy Conference Nears

Noted medical authorities from Michigan and five other states have been obtained as speakers for the 45th Annual Coller-Penberthy-Thirlby Medical Conference at Traverse City, July 29-30.

Frank H. Power, M.D., Traverse City, co-chairman of the conference, reports that "with the passing of Doctor Coller, we, of course, lost our cofounder and major sponsor, and it is with a great sense of pride that I can report that his many friends in Ann Arbor and Detroit, headed by A. James French, M.D., of the Pathology Department, have taken over the continuing provisions of a program for this outstanding event."

The morning program on July 29 will offer "The Surgical Treatment of Gastric Ulcer" by Lester R. Dragstedt, M.D., University of Florida-Gainesville; "Radiology's Debt to Surgery" by Fred J. Hodges, M.D., U-M; "Diseases Associated with Intestinal Polyposis" by William A. Altemeier, M.D., University of Cincinnati; "Synovectomy for Chronic Synovitis" by Carl E. Badgley, M.D., U-M; "The Healing of Myocardial Infarct" by Richard J. Bing, M.D., Wayne State University. The afternoon will continue with "Surgical Problems in the Gastroesophageal Area" by Alan P. Thal, M.D., WSU; "Scleredema Adultorum—Its Differentiation from Systemic Sclerosis" by Arthur C. Curtis, M.D., U-M; "Physiology of Repair Solutions," by Mark A. Hayes, M.D., Yale University; "Valves in the Urethra of Male Children" by Reed M. Nesbit, M.D., U-M; "The Etiology of Recurrent Hernia in the Groin" by Chester B. McVay, M.D., University of South Dakota; "15-Year Study of Breech Delivery at the U-M Medical Center" by George M. Morley, M.D., U-M; "Vascular Injuries" by Marion S. DeWeese, University of Missouri; "Chronic Pancreatitis" by Charles G. Child, III, M.D., U-M.

The evening program will be announced later.

On Friday morning, July 30, the Conference will offer "Penicillin Derivatives" by G. Thomas McKean, M.D., WSU; "Present-Day Treatment of Carcinoma of the Breast" by Henry K. Ransom, M.D., U-M; "Recent Advances in Diagnosis and Management of Nephrotic Syndrome in Children" by William J. Oliver, M.D., U-M; "Clinical Experience with Renal Homotransplantation" by Ralph A. Straffon, M.D., Cleveland Clinic; "The Effect of Therapeutic Drugs on Anesthesia" by Robert B. Sweet, M.D., U-M; and "The Complications of Tracheostomy" by Merle M. Musselman, M.D., University of Nebraska.

# ANCILLARY SECTION

## *Shanty Creek Course Attracts Attention*

Considerable interest has been shown in the new venture of the University of Michigan Department of Postgraduate Medicine to sponsor a summer conference—at such a popular resort place as Shanty Creek Lodge near Bellaire, June 28 through July 2.

The five-day course is entitled, "Selective Topics in Diagnosis and Treatment of Some Common Medical Problems."

The faculty for the postgraduate program will include Doctors Charles G. Child, III, Jerome W. Conn, Arthur C. Curtis, Franklin D. Johnston, Norman F. Miller, James L. Wilson, and Raymond W. Waggoner.

Full details may be obtained from the U-M Department of Postgraduate Medicine. John M. Sheldon, M.D., department director, reports that the daily program will include four hours of lecture and discussion followed by informal discussions later in the day, and a movie and discussion each evening.

## Doctor Jaffe to Head Plastic Surgeons

Harold W. Jaffe, M.D., Detroit, is the new president of the Michigan Academy of Plastic Surgery, elected recently at Ann Arbor. Also serving are Andrew E. Stefani, M.D., Detroit, secretary-treasurer. Elected to the Board of Directors were Ralph Blocksma, M.D., Grand Rapids; Wallace Steffensen, M.D., Grand Rapids, and Robert Pool, M.D., Birmingham.

## 1964 WINNER

The winner as "Best of the Show" Award in 1964 at the Doctors-Wives Art Show was Marion W. Jocz, M.D., Center. Mrs. L. Jerome Fink was the chairman last year. The Auxiliary Committee, planning the 1965 Art Show, expects many more entries this year as the exhibit moves to Cobo Hall during the MSMS Centennial.

## "Adolescent Medicine" Chosen as U-M Topic

About 400 physicians from Michigan are expected to attend the Seventh Annual Merck Sharp and Dohme Conference at the University of Michigan June 25-26 on "Adolescent Medicine."

Program details may be obtained from the U-M Department of Postgraduate Medicine or from Conference Chairman George H. Lowry, M.D.

The conference will begin at 8:30 a.m., June 25 and conclude at 5 p.m., June 26. Out-of-state speakers will include Willard Allen, M.D., University of Washington; Benjamin Balser, M.D., Columbia University; Edward J. Hornick, M.D., Albert Einstein Medical School; Allan C. Barnes, Johns Hopkins; Willard D. Boaz, M.D., Western Reserve, and others.

## PICK SPEECH WINNERS IN AUXILIARY PROJECT

More than 3,000 students in 76 Michigan high schools participated in the 23rd annual TB Speaking Project. The project was co-sponsored again by the Michigan Tuberculosis and Respiratory Disease Association and the Woman's Auxiliary to the Michigan State Medical Society and the local affiliates of the two groups.

Mrs. E. C. Galsterer, of Saginaw, served as state chairman for the Woman's Auxiliary to MSMS.

The top six winners gave their talks over radio station WKAR on the Michigan State University campus. Ten others received honorable mention.

## New Hemophilia Help Coming to Michigan

Robert J. Molhoek, President of the Michigan Chapter of the National Hemophilia Foundation, recently announced the establishment of the Hemophilia Fund at the University Hospital in Ann Arbor.

The Fund will support free laboratory work-ups for all known or suspected hemophiliacs in the State of Michigan and doctors throughout the State are urged to feel free to offer this service to any of their patients wherever there is a question as to the form or severity of their hemophilia. Arrangements can be made by telephoning Ann Arbor 764-8104.

It is the intent of the Foundation to establish in Ann Arbor a file card on each patient so that any physician can call at any time and receive authoritative information and advice about any patient with this disease that he might be called upon to see.

The patients will be given identification cards with the accurate information on their individual cases of hemophilia and these will incorporate the Medic-Alert symbol as recommended by the Michigan State Medical Society.

A medical advisory council to the Michigan Chapter of The National Hemophilia Foundation has been established, chaired by John Penner, M.D., with Robert Bailey, M.D., Ruth Heyn, M.D., and James Hayward, D.D.S., all of Ann Arbor as members. Additional members are Joseph Venier, M.D., of the Lansing Red Cross, and James Sgouria, Ph.D., of the Michigan State Health Laboratories, Section on Blood Derivatives.

Physicians with an interest in the problems of hemophilia may now become associate members of the Council and it is expected that there will be one such associate in Lansing, Grand Rapids, Flint, Saginaw, Traverse City, and one or more in Detroit. Any interested physician who would care to join the group would be welcomed and should contact John Penner, M.D., at the Simpson Memorial Institute in Ann Arbor, Michigan, or President R. J. Molhoek at the Michigan Chapter headquarters, 2904 Thayer Drive, St. Joseph, Michigan.

The Foundation is also establishing a hemophilia library at the University Medical Center.

## TB SEAL SETS RECORD; TOPS MILLION AGAIN

The final figure of the 1964 Christmas Seal Campaign in Michigan is expected to reach $1,301,000.

This figure represents a $179,000 increase over 1963, or a 16.0 per cent increase in total contributions.

All 83 counties reported this as their biggest campaign in history.

# Editor Sees Michigan Public Waiting for Health Articles

"Opportunities are wide open for the medical profession to work closer with the press so we can provide information for the public—the public is ready."

That observation was voiced by James P. Brown, Jr., editor of the Ypsilanti Press, at the MSMS Conference on Medical Writing, held this spring.

More than 60 editors and reporters from major Michigan newspapers, physicians and journalism professors joined for the workshop at Michigan State University.

Participants were generous with their praise for the program and voiced the need for further conferences.

* * *

"IF THE ARTICLE is interesting and valid, people will read medical news every day," declared Editor Brown. Of the many kinds of news, medical news has a big advantage because people are interested, he added.

The medical profession, he observed, has a major block in trying to talk to reporters and the laymen —many doctors cannot communicate on technical subjects. "If you have something to say, say it so we can understand it, please."

* * *

MICHIGAN NEWSPAPERS were praised by MSMS officials during the conference. MSMS President Oliver B. McGillicuddy, M.D., presiding at the dinner at the MSMS headquarters, declared that "the newspaper is used by many Michigan citizens as a 'health education text book,'" R. Wallace Teed, M.D., Ann Arbor, chairman of the MSMS Public Relations Committee, observed that "the Michigan press has high standards of journalistic ethics."

In addition to the names of the physicians listed below, the dinner speech was given by C. Howard Ross, M.D., Ann Arbor, president of the Michigan Medical Writers Association; the afternoon panel was moderated by C. J. Tupper, M.D., Associate Dean of Medicine at the University of Michigan; and the evening program was led by Paul T. Chapman, M.D., president of the Michigan Tuberculosis and Respiratory Disease Association.

H. Clay Tellman, M.D., Muskegon, and Edwin O. Pearson, M.D., Kalamazoo, served on a reactor panel.

Lead-off speaker at the conference was James P. Brown, Jr., standing, editor of the Ypsilanti Press. Panel participants included, left to right, F. P. Rhoades, M.D., Detroit; Jean Pearson, Detroit Free Press science writer; C. J. Tupper, M.D., Ann Arbor; Mr. Brown; Andrew D. Hunt, M.D., East Lansing, seated behind Mr. Brown; William Bender, Jr., Ann Arbor, and at the far right, R. Wallace Teed, M.D., Ann Arbor.

The conference participants were welcomed to the MSU campus by Andrew D. Hunt, M.D., MSU Dean of the College of Human Medicine.

Cosponsors for the conference were MSMS, MTRDA, and the MSU School of Journalism and College of Human Medicine.

* * *

"THE FIRST THING a reader wants to know is 'what does this mean to me, my family or friends and their problems, and what is the practical use?'"

So stated Jean Pearson, Detroit Free Press science writer. She suggested that the view of the public is one side of a triangle which also includes the physician and the press. The press wants to keep its readers up-to-date on the latest information, and the physicians want to educate the public about health matters and to encourage each person to attain and maintain his best possible level of health.

Miss Pearson added that "we might be getting into trouble because the public, press and physician each has its own distinctive point of view and its own form of myopia."

The major fault of the public, she indicated was that "they want to be entertained and they do not want a medical story cluttered with limiting qualifications."

Physicians are not perfect either, she said, and added that "they believe they should be the judge of what the public should know and what should

## DIGESTS AVAILABLE

**Digests of the Conference on Medical Writings are available from the Michigan State Medical Society, P.O. Box 152, East Lansing. Digests of the evening address by Irvine H. Page, M.D., Director, Research Division, Cleveland Clinic Foundation, are available from the Michigan Tuberculosis and Respiratory Disease Association, 403 Seymour, Lansing.**

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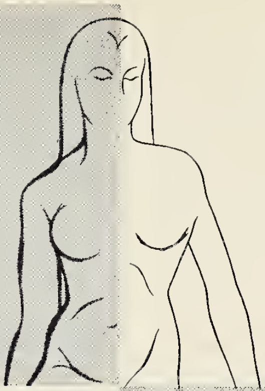

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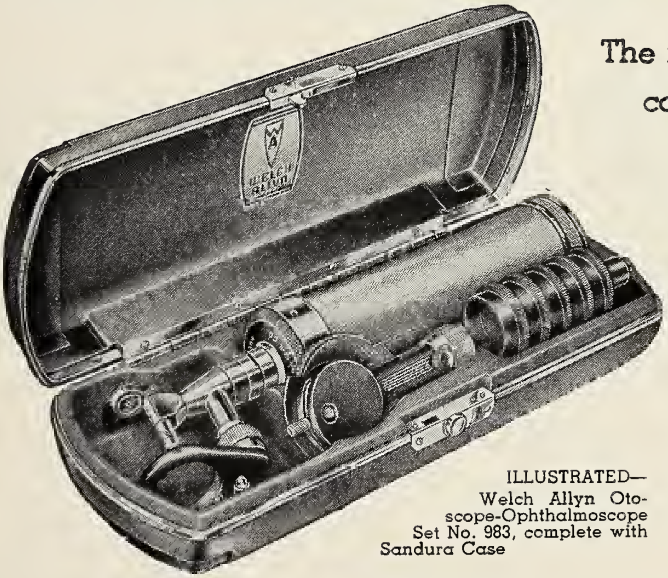

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not go into its shell-like innocent ears or through its trusting, wide eyes."

Miss Pearson recommended that the medical story should be told simply, accurately, interestingly and as logically as it can be presented. She urged that the story be told, if possible, with necessary limitations, qualifications and a statement of what still remains to be learned or done."

* * *

"THE ACHIEVEMENT of good medical-press relations," observed Larry Bush, Ann Arbor News science writer, "hinges on a high level of understanding on the part of journalists and physicians of each other's problems and attitudes.

"Physicians need a better understanding of newspaper deadlines, the problems editors face in writing headlines, and the problems reporters have in translating the language of the physician for the general public."

On the list of press problems, Mr. Bush expressed special concern because "many times newspaper people are shackled by the straight jacket of tradition in news selection."

Mr. Bush praised the efforts of the National Council for the Advancement of Science Writing Trainee Program.

* * *

"SCIENCE WRITERS help explain the 'new in medicine' and pave the way for physicians in many instances," declared F. P. Rhoades, M.D., president of the Wayne County Medical Society.

He recognized that writers have a problem in trying to write the story concise, but with sufficient detail. Unless the details tell the limitations of new drugs, etc., the articles are apt to play up sensationalism.

* * *

THERE ARE THREE basic areas of conflict between doctors and newsmen, declared Milton S. Weed, M.D., past president of the Wayne County Medical Society.

He listed the three as . . .

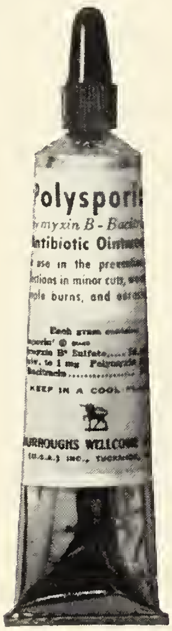
1. The use of names of doctors.
2. The concept of time.
3. And "Where lieth the right."

Doctor Weed declared, "It seems to me that all physicians by every means available, ought to cultivate intelligent understanding and honest cooperation with newspapermen in the interest of accurate medical news.

"Medicine, in self-interest," Doctor Weed said, "needs good science reporting to interpret its discoveries, health information and viewpoints to the public which supports it."

* * *

WILLIAM BENDER, Jr., Public Information Officer, University Hospital, Ann Arbor, said the hospital writer and the science writer need to translate new techniques, drugs, procedures, apparatus, tests and operations, and also preventive measures that will avoid illness and injury. The writer has two essential choices, Mr. Bender said. He can select the audience he wants to reach, and within certain limits he can select the topic he wants to write about. He inferred that the author cannot stick to the topic he wants to cover and ignore the readers.



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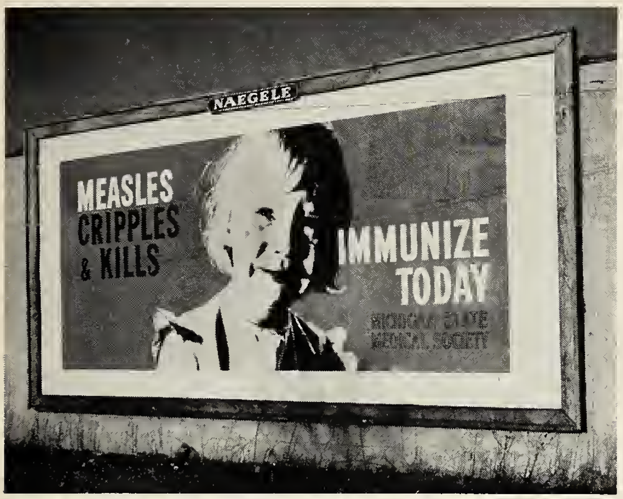

## BILLBOARDS, TOO

Many billboards were utilized across the state to help urge parents to take their children to their family physicians for measles immunization. The billboard signs, up during April and May, were used along with news releases, radio programs, television programs, and other communication approaches as part of the MSMS Measles Education Effort. (Photo of billboard at Twelve Mile and Greenfield in metropolitan Detroit by Michigan Medicine.)

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### *Kalamazoo Medical Care Study Available to MSMS Members*

A limited number of copies of the "Study of Medical Care in Kalamazoo" is available for MSMS members interested in the possible evaluation of medical care in their own communities. To obtain a copy, write to MSMS, 120 West Saginaw, Box 152, East Lansing.

### *4.5 Visits to Physician Per Person in Nation*

The Health Insurance Institute, reporting on data from the U. S. National Health Survey, says that during the 12-month period ending June of 1964 there were 844 million visits (including telephone consultations) made by physicians in the United States for diagnosis, treatment and advice.

That figure averages out to 4.5 visits for each person in the U.S. civilian non-institutional population.

As high as that figure might sound, it is still lower than the 5.3 visit average reported for the population in the 12-month period ending in June 1958, the time of the Asian flu epidemic.

The NHS study also revealed that two-thirds of the population had seen a doctor within the past year and 98.7 per cent of those questioned said they had consulted a doctor some time during their lives.

### *Lesson in Philosophies!*

The socialist-communist theme "from each according to his ability" and "to each according to his need" is neatly slaughtered by Thomas J. Shelly, a teacher at Yonkers High School. . . . Whenever students express admiration for communism, Mr. Shelly always offers to juggle their grades, taking from the high marks to add to the low marks, thus producing an average grade just above passing. When the students realize that this system removes all incentive for learning, they are quickly disillusioned and begin to believe in private enterprise. (Reprinted from the *Indiana Medical Journal.*)

## More and More Covered By Health Insurance

By the end of 1964, an estimated 149 million Americans were protected by some form of health insurance against the costs of ill health, the Health Insurance Institute reports.

This figure represents 78 per cent of the U. S. civilian population, the Institute said, and is an increase of 3.7 million persons over the number protected in 1963.

Record highs were established in 1964 in both the number of persons protected and in the amount of the benefits paid out. Benefits paid to insured persons last year were estimated at $8.6 billion or approximately $800 million more than in 1963.

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# IN MEMORIAM

## JOSEPH L. FLEMING, M.D.

Joseph L. Fleming, M.D., 46, orthopedic surgeon, died April 28 at Ford Hospital in Detroit.

Doctor Fleming was graduated from the University of Chicago and served internship and residency in hospitals in Brooklyn, New York, and Boston, Massachusetts. He practiced orthopedic surgery at Ford Hospital for 15 years and made his home at Orchard Lake.

Doctor Fleming was a member of the Clinical Orthopedic Society, the American Academy of Orthopedic Surgery and a Fellow of the American College of Surgeons.

During World War II Doctor Fleming served as a major in the United States Army.

## JOHN L. JOHNSTON, M.D.

John L. Johnston, M.D., 65, retired Detroit physician, died April 12 at his residence.

Doctor Johnston was graduated from McGill University Faculty of Medicine, Montreal, in 1924. He retired from his practice in 1945. Doctor Johnston was an Associate Member of the Michigan State Medical Society.

## SOLOMON P. MIRAL, M.D.

Solomon P. Miral, M.D., 58, Detroit physician for 31 years, died April 28 in Sinai Hospital.

A 1934 graduate of the Wayne State University School of Medicine, Doctor Miral was engaged in the general practice of medicine. His hospital affiliations included St. Francis of Hamtramck and Brent of Detroit. Doctor Miral was a resident of the Detroit area for over 50 years.

## EDWARD A. MILLER, M.D.

Edward A. Miller, M.D., 80, former well-known Berrien Springs physician, died in Virginia Mason Hospital, Seattle, Washington, April 26.

Born in Pittsburgh, Pennsylvania, Doctor Miller received his medical degree from the University of Michigan School of Medicine in 1910. Doctor Miller practiced in Berrien Springs from 1916 to 1963 when he retired and moved to Washington.

Doctor Miller was a Retired Member of the Michigan State Medical Society.

Doctor . . .

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# Readers Write:

Editor:

Mr. Hardwick's article in the February, 1965, issue of Michigan Medicine raises several philosophical points too often overlooked by writers of cliches such as "the American way of life", and "freedom and individual liberty." These are all fine, excellent phrases, but phrases badly in need of more explicit definition. I have increasingly been impressed with how frequently such terminology and phraseology serves only to defend the static and sterile concept of the status quo. I do not see that Mr. Hardwick's article serves any useful purpose whatsoever, for in it he demonstrates no vision for the future, purposes no solutions to problems, and attempts to rally support by finding socialism behind any contrary view. This approach does medicine a great disservice.

I will not attempt my own definitions of these terms, for I think it obvious that they do mean quite different things to different people. I should like to expand a bit about some of my own thoughts in this area. I do not claim originality, but only, I hope, some sort of rational synthesis. First of all, there is no perfect freedom or individual liberty for any man as a member of an organized society, but only relative freedom or liberty. Man does not exist for himself alone unless he be a solitary hermit shunning civilization. His work or profession is his contribution to society, and his actions impinge or have some effect in other individuals. If we are not to live in the barbarism of the jungle, then each must yield a portion of his freedom and liberty in recognition of inherent rights of others in order that society can work. Fortunately, for civilization as we know it in the West, most men voluntarily recognize this and govern their lives, privately and publicly, by unwritten as well as inscribed codes of conduct in the form of ethics or laws. A certain loss of freedom and liberty results, there is no doubt, but who would have it otherwise?

There is a higher and more noble concept in the affairs of men than freedom and liberty, and that is *justice*, which I would define as the state of fair and right relationship between individuals and groups composing society. Justice rarely results from the magnanimity of an individual, nor, especially, from the unselfish actions of a group. Self-interest is much too strong a motivation of action on the part of groups. Justice is much more likely to result from this resolution of tension built up between contending parties, or from the amicable settlement of disagreements.

What does this have to do with medicine, or, more specifically, with Mr. Hardwick's article? The medical profession is a group with a strong self-interest in the preservation of the status quo. We have our sacred concepts which have indeed served well in the past, and we are unwilling to examine them critically now to see whether they will still have validity. The public, as consumers of our services, has been developing an increasing dissatisfaction with the socio-economic, not the scientific, aspects of medical care. A tension of considerable magnitude is thereby being created and this tension must be resolved. Thus far, we in medicine have shown a minimum of imagination and creativity with respect to the many problems facing us, and a maximum of opposition to any plans or proposals which threaten to change the traditional system. Consequently, we shall probably have Medicare which has a lot of deficiences, instead of Eldercare which has a lot of merit. What would the result have been if Eldercare had been supported four or five years ago? I can recall that the basic ideas were being discussed at that time. What will the effect be now and in the near future if we were to propose or to consider alternatives to present programs of care for all age groups? The initiative must come from medical leadership and be promoted among the physicians, or it will come from elsewhere as there is every indication it is right now.

Mr. Hardwick's example of the state of the railroads is a fortunate one to support my thesis rather than his. The tremendous abuse and flagrant disregard of the public good by railroad ownership and management in the late 1800's were a national scandal and disgrace. Unbridled, unprincipled, and unhindered freedom of enterprise accompanied by a *public-be damned, we-know-best* attitude brought on the government regulations that now undoubtedly do need some revision in the public interest and for the good of railroad operation. Would the I.C.C. and the other regulatory bodies have been necessary if railroad management had been more enlightened? I think not! Of course, Mr. Hardwick conveniently overlooks the greatest source of difficulty the railroads face today, and it is not burdensome regulations but rather the competitive modes of transportation.

My point here is not to engage in sterile arguments. My plea is rather for a medical statesmanship. Surely this great profession must have many men with breadth of vision sufficient to encompass the broad, ever-changing, ever-improving, ever self-appraising American society, and who are willing to examine the profession's role in this society. A purely defensive view, protecting our own version of the "American way of life", is doomed to failure. Government, as umpire and arbitrator of the American scene, will then be forced to resolve the tension. We may or may not like the solution, but unless we contribute more creatively to the dialogue, we will get little of what we desire, and probably a great deal less than we deserve.

Yours truly,

Charles A. Leach, M.D.
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**Hilda B. Case, M.D.**, 261 Mack Blvd., Detroit 1, Michigan
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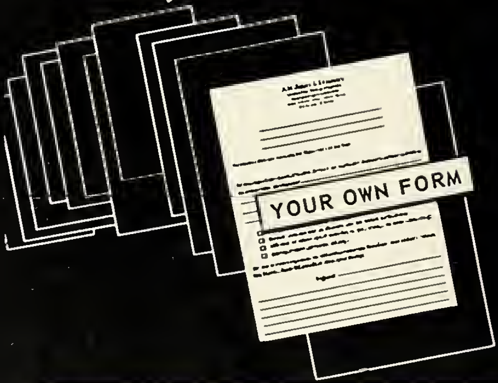

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# Reporting as Ordered

### A Monthly Commentary
### By HUGH W. BRENNEMAN, Executive Director

Medicine's friends are constantly at work assisting the profession. When MSMS Associate Executive Director Warren Tryloff and his assistant, Miss Katie Brewbaker, sent out invitations to some of the profession's friends inviting them to exhibit at the Centennial Session, the response was heartening. Nearly every space in the technical exhibit was sold six months before the Centennial Session. It appears that both the technical and scientific exhibits will be the finest MSMS has ever had.

* * *

Belaboring the thought that medicine has many friends, you should see the contents of the literature supply and storage room at headquarters—pamphlets and brochures on nearly every conceivable subject in the health field. Although all of the materials are doctor approved, most are supplied by medicine's friends—the Reader's Digest, the TB and RD Association, the American Cancer Society, the Michigan Cancer Foundation, Blue Cross-Blue Shield, Michigan Hospital Association, Michigan State Pharmaceutical Association, Michigan Nurses Association, Michigan Society of Hospital Pharmacists, Pharmaceutical Manufacturers Association, American Medical Research Foundation, U. S. Department of Defense (Office of Civil Defense), American Psychiatric Association, Metropolitan Committee on Aging, National Committee on School Health Policies, Metropolitan Life Insurance Company, Automobile Club of Michigan, Michigan State University, the University of Michigan—not to mention such friendly in-the-family groups as the AMA and the Student AMA.

This supply of literature covers subjects such as the "Congress on Mental Health," "One Car Accidents and the Young Driver," "Mortality Differentials in Michigan," "The Fifth Freedom—(freedom of choice of doctor)," "A P.R. Pattern for a Successful Practice," "When Our Parents Get Old," "Suggested School Health Policies," "Not Just Exercise," "Home Protection Exercises," "Psychological First Aid," "Perinatal Study," "Medical Education Loans," "Nationwide Survey on County Medical Society Activities," "Health—Unlock Your Community Resources," "Uniting Against Cancer," "New Directions Toward Community Mental Health," "A New Way to Cut Out Smoking."

These publications give the profession a great deal of help with its public relations efforts—if the doctor chooses to use them.

* * *

The profession has constant friends in the various medical alma maters. One hundred and twenty medical schools have graduates practicing in Michigan. Dean Hubbard, U of M, Dean Gardner, WSU, and Dean Hunt of the fledgling MSU College of Human Medicine have repeatedly evidenced interest in the education and welfare of the profession outside the ivied walls of their respective campuses. This has proven true again and again in legislative efforts. It has always been true in educational programs—witness the participation in the excellent Spring 1965 Extramural Courses for Michigan Physicians jointly sponsored by the U of M, WSU, the Michigan Department of Health and the MSMS.

* * *

We've barely scratched the surface of the services friends of medicine in Michigan offer daily. Consider the M.D. Placement Program of the Michigan Health Council. Don't forget its collaboration with the Michigan Association of the Professions in putting on hundreds of hours of television broadcasts—with fine cooperation from the entire Michigan TV and radio industry—and the recognized national success of Michigan's Community Health Week would have been impossible without MAP and MHC. Look at their support of the Measles Campaign by Merck, plus the distribution of our literature by the Michigan PTA, and the Adult Education Association among a host of others.

And, in spite of an occasional jibing editorial, the profession has friends among the press as was indicated by the well-attended Michigan Conference for Science Writers in Lansing in April.

The well-received visits of MSMS officers with the congressional delegation in Washington, D. C., was indicative that in spite of votes that occasionally go astray we do have friends in the National Congress.

One area of friends that really is surprising is the great interest in medicine shown by privately organized research and development. Their reports received in the MSMS office each month are a little short of amazing!

* * *

That last item was purposefully kept to this point in this article so that emphasis could fall on the very real fact that whereas the profession has all sorts of friends who are serving it, the only way that maximum gains can be made from such good company is by an organization, medicine's own, *knowing where it is going and being pretty sure of how to get there.*

To do that requires some concentrated, organized "research and development" on the part of this organization. Perhaps considerably more than we have had in the past. Because of the rapid speed of today's developing sciences both physical and social, the outfit that isn't using computers to keep score just isn't going to be in the game for very long. The House of Delegates and The Council are not unaware of this. O. J. Johnson, M.D., commented upon this at the last meeting of The Council and was asked to make some concrete recommendations. This may be the biggest thing the MSMS embarks upon as it begins its second century of service

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